United States v. State of Texas

Monitoring Team Report

San Antonio State Supported Living Center

Dates of Onsite Review: November 2-6, 2015

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Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with intellectual and developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers the 12 State Supported Living Centers (SSLCs), Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo, and San Antonio, and the Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) component of the Rio Grande State Center.

In 2009, the parties selected three Independent Monitors, each of whom was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that were submitted to the parties. Each Monitor engaged an expert team for the conduct of these reviews.

In mid-2014, the parties determined that the facilities were more likely to make progress and achieve substantial compliance with the Settlement Agreement if monitoring focused upon a small number of individuals, the way those individuals received supports and services, and the types of outcomes that those individuals experienced. To that end, the Monitors and their team members developed sets of outcomes, indicators, tools, and procedures.

Given the intent of the parties to focus upon outcomes experienced by individuals, some aspects of the monitoring process were revised, such that for a group of individuals, the Monitoring Teams' reviews now focus on outcomes first. For this group, if an individual is experiencing positive outcomes (e.g., meeting or making progress on personal goals), a review of the supports provided to the individual will not need to be conducted. If, on the other hand, the individual is not experiencing positive outcomes, a deeper review of the way his or her protections and supports were developed, implemented, and monitored will occur. In order to assist in ensuring positive outcomes are sustainable over time, a human services quality improvement system needs to ensure that solid protections, supports, and services are in place, and, therefore, for a group of individuals, these deeper reviews will be conducted regardless of the individuals' current outcomes.

In addition, the parties agreed upon a set of five broad outcomes for individuals to help guide and evaluate services and supports. These are called Domains and are included in this report.

Along with the change in the way the Settlement Agreement was to be monitored, the parties also moved to a system of having two Independent Monitors, each of whom had responsibility for monitoring approximately half of the provisions of

the Settlement Agreement using expert consultants. One Monitoring Team focuses on physical health and the other on behavioral health. A number of provisions, however, require monitoring by both Monitoring Teams, such as ISPs, management of risk, and quality assurance.

Methodology

In order to assess the facility's compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities:

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed. The amount of documentation requested by the Monitoring Teams decreased with the changes in the way monitoring was being conducted.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Scoring** – The report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. The parties agreed that compliance determinations would not be made for the Domains or for the outcomes for this round of monitoring reviews. Therefore, none of the figures in this report should be construed as a statement regarding the Facility's compliance with the Settlement Agreement.

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

a. **Domains:** Each of the five domains heads a section of the report.
b. **Outcomes and indicators:** The outcomes and indicators are listed along with the Monitoring Teams' scoring of each indicator.
c. **Comments:** The Monitors have provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
d. **Individual numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers.
e. **Numbering of outcomes and indicators:** The outcomes and indicators under each of the domains are numbered, however, the numbering is not in sequence. Instead, the numbering corresponds to that used in the Monitors' audit tools, which include outcomes, indicators, data sources, and interpretive guidelines/procedures (described above). The Monitors have chosen to number the items in the report in this manner in order to assist the parties in matching the items in this report to the items in those documents. At a later time, a different numbering system may be put into place.

Executive Summary

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at the San Antonio SSLC for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The Facility Director supported the work of the Monitoring Teams, and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

Status of Compliance with the Settlement Agreement

Domain #1: The State will make reasonable efforts to ensure that individuals in the Target Population are safe and free from harm through effective incident management, risk management, restraint usage and oversight, and quality improvement systems.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.

			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	8/12 67%	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	3/7 43%	N/A	1/1	0/1	1/1	0/1	N/A	0/1	0/1	1/1

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (January 2015 through September 2015) were reviewed. In addition, following the onsite review, the facility submitted a narrative with additional information about many of these sets of data and graphs.

The data did not show a decreasing trend in the frequency of crisis restraint usage over the past nine months; the highest frequencies were in the most recent two months (28 and 16, respectively). Of these crisis restraints, physical restraints and chemical restraints did not show a decreasing trend. Chemical restraints were applied for Individual #154 and Individual #264 in September 2015 more so than ever before, due to their psychiatric instability (which is discussed in various sections of this report). Further, the behavioral health services director reported that, in the past, the use of chemicals (i.e., medication) had been categorized as psychiatric emergency medication administration (PEMA), but now was being (more appropriately) categorized as chemical crisis intervention restraint.

Mechanical crisis restraints remained low throughout the period. Mittens were used with two individuals to interrupt intense hand biting. Continued use was not needed. The average duration of each physical restraint was low and decreasing, to around three minutes during the most recent month. The number of injuries that occurred as a result of application of restraint was low (averaged less than one per month) and none were deemed serious.

The number of different individuals who were restrained for crisis intervention showed an increasing trend over the nine months and is probably a topic worthy of review by the behavioral health services and quality assurance departments. The number of different individuals who had protective mechanical restraint for self-injurious ranged from zero to two each month. There were reasonable rationales for the need for the restraint. The amount of time in (or out) of protective mechanical restraint should be a regular part of the data system for those individuals.

The use of chemical and non-chemical restraints for medical and dental procedures was low for the nine-month period.

Thus, state and facility data showed low usage and/or decreases in eight of these 12 facility-wide measures (i.e., duration of crisis intervention physical restraint, crisis intervention mechanical restraint, use of protective mechanical restraint for self-injurious behavior, restraint related injuries, chemical and non-chemical restraint for medical and dental).

2. Six of the individuals reviewed by the Monitoring Team were subject to restraint. Five were crisis intervention restraints (Individual #154, Individual #346, Individual #264, Individual #130, Individual #39) and one was protective mechanical restraint for self-injurious behavior (Individual #342). Data from state office and from the facility showed decreases in frequency or very low occurrences over the past nine months for two of the five (Individual #346, Individual #39). The behavioral health services director provided additional information about the other three individuals. Individual #154 and Individual #264 were psychiatrically unstable over this period. Some applications of chemical restraint were previously being categorized as PEMA, but were now being, more appropriately, categorized as chemical restraint. This change accounted for some of the increase in frequencies for these two individuals. Individual #130's frequency of restraint was decreasing over the last five months, but over the nine-month period did not show a decrease. The facility reported that new admissions to her home led to increased behavioral problems that resulted in restraint, but that over the past month or so had stabilized again.

To make a determination for Individual #342, the Monitoring Team looked for any data regarding the amount of time the protective mechanical restraint (helmet) was applied (or not applied). Data were not found and were not being collected or reported. The facility should measure time in (or out) of protective mechanical restraint. That being said, the behavioral health services director reported that the plan in place was for the helmet to be removed for 15 minutes every two hours and during the overnight.

The other three individuals did not have any occurrences of crisis intervention restraint or protective mechanical restraint for self-injurious behavior. The Monitoring Team looked to see if any of these individuals had any restraints in the nine-month period preceding the nine-month period reviewed (i.e., March 2014-November 2014). If so, they would then be included as an individual who had shown progress in the reduction of restraint occurrences. One of these three individuals had one restraint in that prior nine-month period and, therefore, was included in this indicator (Individual #42).

Also of note, the facility reported that protective mechanical restraint was no longer needed and was, therefore, eliminated for two individuals over the past nine months (Individual #138, Individual #149).

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.

			Individuals:								
#	Indicator	Overall Score	154	346	130	264	342	39			
3	There was no evidence of prone restraint used.	100% 11/11	2/2	2/2	2/2	2/2	1/1	2/2			

4	The restraint was a method approved in facility policy.	100% 11/11	2/2	2/2	2/2	2/2	1/1	2/2			
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 10/10	2/2	2/2	2/2	2/2	N/A	2/2			
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	50% 3/6	N/A	1/2	0/2	1/1	N/A	1/1			
7	There was no injury to the individual as a result of implementation of the restraint.	100% 11/11	2/2	2/2	2/2	2/2	1/1	2/2			
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 11/11	2/2	2/2	2/2	2/2	1/1	2/2			
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/7	0/2	N/A	0/2	0/2	0/1	N/A			
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 10/10	2/2	2/2	2/2	2/2	N/A	2/2			
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	9% 1/11	0/2	0/2	0/2	0/2	1/1	0/2			

Comments:
The Monitoring Team chose to review 11 restraint incidents that occurred for six different individuals (Individual #154, Individual #346, Individual #130, Individual #264, Individual #342, Individual #39). Of these, six were crisis intervention physical restraints, four were crisis intervention chemical restraints, and one was the use of protective mechanical restraint for self-injurious behavior. The crisis intervention restraints were for aggression to staff or peers, unauthorized departure that placed the individual in a dangerous situation, and/or self-injurious behaviors.

5. The two crisis intervention restraints for Individual #154 were chemical restraints that occurred on two consecutive days as a result of what the restraint documentation said was “yelling, screaming, pacing continuously for the last two days and no sleep for past 24 hours" and "grabbing and punching." The documentation should more clearly indicate how this was a crisis situation in which there was immediate and serious risk of harm. During discussion with the Monitoring Team, the behavioral health services director provided a more in depth description of Individual #154’s behavioral presentation at these times. This was helpful to the Monitoring Team. Moreover, in the past, this type of occurrence was scored as PEMA. The facility had, appropriately, moved to categorizing, managing, and monitoring this type of occurrence as a chemical restraint.

6. Three of the six physical restraints did not have the proper release code in the documentation (Individual #346 4/15/15, Individual #130 6/13/15 and 7/27/15). These restraint checklists did not show code S (immediately because no longer a danger), but instead showed code Y (release completed).

9. Because criterion for indicator #2 was met for Individual #346 and Individual #39, this indicator was not scored for them. For the

others, there were PBSPs in place, but little validation that those PBSPs were implemented as written and that data were correctly and reliably recorded. For all individuals, the lack of consistent psychiatric services was evident (and is described in more detail below in this report). For Individual #342, a time out of protective mechanical restraint was described, but data regarding implementation were not being collected or monitored.

11. The IRRF section of the ISP did not show a selection of one of the two options in the template to document restraint considerations for all individuals, except for Individual #342.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.

			Individuals:								
#	Indicator	Overall Score	154	346	130	264	342	39			
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			

Comments:

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.

			Individuals:								
#	Indicator	Overall Score	154	346	130	264	342	39			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	90% 9/10	2/2	1/2	2/2	2/2	N/A	2/2			
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

13. All restraints met criterion for this indicator, except for Individual #346 4/15/15, for which the restraint was initiated at 6:55 pm and the restraint monitor arrived at 7:15 p.m., just beyond the required time.

14. This indicator did not apply to any of these restraint occurrences.

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
			Individuals:								
#	Indicator	Overall Score	154	346	130	264	342	39			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	19% 3/16	0/1	1/2	2/2	0/2	0/7	0/2			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Comments: a. The crisis intervention restraints reviewed included those for: Individual #154 on 3/12/15 at 10:15 a.m.; Individual #346 on 4/15/15 at 6:55 p.m., and on 4/25/15 at 12:55 p.m.; Individual #130 on 6/13/15 at 7:24 p.m., and on 7/27/15 at 1:30 p.m.; Individual #264 on 5/21/15 at 1:35 p.m., and 6/14/15 at 1:17 p.m.; Individual #342 at 9/14/15 at 6:30 a.m. to 9/20/15 at 6:30 a.m.; and Individual #39 on 3/2/15 at 4:58 p.m., and on 6/20/15. Based on the seven days of documentation for Individual #342's PMR-SIB restraint, nursing staff did not conduct and/or documents the necessary physical assessments related to his helmet. Vital signs were monitored and documented for Individual #154 on 3/12/15 at 10:15 a.m.; Individual #346 on 4/15/15 at 6:55 p.m.; and Individual #130 on 6/13/15 at 7:24 p.m., and on 7/27/15 at 1:30 p.m. Mental status descriptions were sufficient for Individual #346 on 4/15/15 at 6:55 p.m., and Individual #130 on 6/13/15 at 7:24 p.m., and on 7/27/15 at 1:30 p.m.											

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.											
			Individuals:								
#	Indicator	Overall Score	154	346	130	264	342	39			
15	Restraint was documented in compliance with Appendix A.	100% 11/11	2/2	2/2	2/2	2/2	1/1	2/2			
Comments: 15. The restraints were documented very well.											

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
			Individuals:								
#	Indicator	Overall Score	154	346	130	264	342	39			
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 10/10	2/2	2/2	2/2	2/2	N/A	2/2			
17	If recommendations were made for revision of services and supports,	100%	2/2	2/2	2/2	2/2	N/A	2/2			

	it was evident that recommendations were implemented.	10/10									
	Comments:										

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
			Individuals:								
#	Indicator	Overall Score	42	154	346	130	142	342	39		
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	64% 7/11	0/1	3/3	0/2	1/1	1/2	1/1	1/1		

Comments:

The Monitoring Team reviewed 11 investigations that occurred for seven individuals. Of these 11 investigations, six were DFPS investigations of abuse-neglect allegations (one confirmed, three unconfirmed, two administrative referral). The other five were for facility investigations of witnessed and discovered serious injuries, an unauthorized departure, and an encounter with law enforcement.

- Individual #42, UIR 15-093, 8/5/15, unauthorized departure
- Individual #154, UIR 15-045, 3/5/15, serious injury fracture
- Individual #154, UIR 15-066, 5/7/15, serious injury fracture
- Individual #154, UIR 15-072, 6/2/15, serious injury fracture
- Individual #346, UIR 15-127, DFPS 43580180, 3/17/15, allegation of neglect, clinical referral
- Individual #346, UIR 15-051, 3/19/15, encounter with law enforcement
- Individual #130, UIR 15-193, DFPS 43774920 6/15/15, unconfirmed allegation of physical abuse
- Individual #142, UIR 15-070, DFPS 43737276, 5/28/15, unconfirmed neglect allegation and serious injury
- Individual #142, UIR 15-077, DFPS 43784730, 6/20/15, confirmed neglect allegation
- Individual #342, UIR 15-142, DFPS 43595413, allegation of neglect, administrative referral
- Individual #39, UIR 15-145, DFPS 43603858, 4/3/15, unconfirmed allegation of physical abuse

1. For all 11 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes the occurrence of staff criminal background checks and signing of duty to report forms; facility and IDT review of trends; and the development, implementation, and revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

In all cases, criminal background checks were conducted and staff signed the annual acknowledgement of their reporting responsibilities. For 6 of the 11, the facility had identified trends and/or prior occurrences and there were protections and plans in place. For four others, there was no trend or prior occurrence. For Individual #42, there were previous occurrences of unauthorized departure in the past year, but this behavior was not addressed in his PBSP. This was also noted by the facility's investigator in the UIR.

Plans were implemented and effectiveness was monitored for Individual #154's three investigations and for one of Individual #142's investigations (UIR 15-077). Plans were not needed for three for which there were no trends or prior history (Individual #130, Individual #342, Individual #39). For the others, PBSPs were developed, but not implemented regularly or always correctly (Individual #346 15-127 and 15-051, Individual #142 15-070).

Regarding Individual #142, in addition to the Monitoring Team's review, the facility investigator reported in the UIR that witness statements did not support that staff implemented strategies in his PBSP to minimize aggression. The UIR included a recommendation that staff be retrained on Individual #142's PBSP. Regarding Individual #346, similar problems in implementation of the PBSP were found by the Monitoring Team, including no evidence that staff were trained on the PBSP or that the plan was revised when progress was not made.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.

			Individuals:								
#	Indicator	Overall Score	42	154	346	130	142	342	39		
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	64% 7/11	0/1	2/3	2/2	1/1	0/2	1/1	1/1		

Comments:

2. The Monitoring Team rated seven of the investigations as being reported correctly. The others were rated as being reported late. All were discussed with the facility Incident Management Coordinator while onsite. This discussion along with additional information provided to the Monitoring Team informed the scoring of this indicator. Those not meeting criterion are described below.

- Individual #42, UIR 15-093, the UIR states that his mother reported the departure to the facility at 12:45 pm, however, in the next section, this reporting is noted to have occurred at 11:37 am. The cover sheet of the UIR shows it was reported at 1:05 pm the next day. The state, in its response to the draft report, provided additional information, however, when there are apparent inconsistencies in date/time of events, the UIR itself should explain them (in much the same way the state did in its response), and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.
- Individual #154, UIR 15-072, the fracture was confirmed (at the Facility, by the mobile x-ray unit) at 1:35 pm. It was reported to the facility director at 2:56 pm. Although this was just past the one hour requirement, and although the physician determination occurred at 2:00 pm, once a fracture is confirmed, it is evident that it is a serious incident that needs to be reported immediately by whomever has the knowledge that a fracture has been confirmed (in this case it was a facility staff, probably a nurse, who accompanied the individual in the mobile x-ray unit). That is, staff should not be waiting for the coding by a physician.
- Individual #142, UIR 15-077, the incident occurred at 7:21 am and was reported to DFPS at 10:53 am. There was no explanation in UIR about the circumstances of the late reporting.
- Individual #142, 15-070, the UIR and DFPS reports showed that the injury (which required emergency room treatment) occurred at 1:00 pm and reported to the facility director at 1:52. The injury report showed the injury was coded as serious at 2:40 pm. The DFPS report showed it was reported to DFPS as an allegation of abuse at 3:30 pm and the UIR shows that DFPS

reported it to the Facility at 4:53 pm. The DFPS report does not have an entry in the "date and time of facility director notification" line. Nothing in the UIR provided an explanation as to this reporting time sequence issue and what appeared (without further explanation) to be late reporting. The state, in its response to the draft report, said that reporting information was within the narrative. Even so, the facility needs to identify these types of salient mistakes when it does its own reviews of DFPS reports.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.											
			Individuals:								
#	Indicator	Overall Score	42	154	346	130	142	342	39		
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 5/5	Not scored	Not scored	1/1	1/1	1/1	1/1	1/1		
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 6/6	Not scored	1/1	1/1	1/1	1/1	1/1	1/1		
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 11/11	1/1	3/3	2/2	1/1	2/2	1/1	1/1		
Comments:											

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.											
			Individuals:								
#	Indicator	Overall Score	42	154	346	130	142	342	39		
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 11/11	1/1	3/3	2/2	1/1	2/2	1/1	1/1		
Comments:											

Outcome 5– Staff cooperate with investigations.											
			Individuals:								
#	Indicator	Overall Score	42	154	346	130	142	342	39		
7	Facility staff cooperated with the investigation.	100% 11/11	1/1	3/3	2/2	1/1	2/2	1/1	1/1		
Comments:											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
			Individuals:								
#	Indicator	Overall Score	42	154	346	130	142	342	39		
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	91% 10/11	1/1	2/3	2/2	1/1	2/2	1/1	1/1		
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	82% 9/11	1/1	2/3	1/2	1/1	2/2	1/1	1/1		
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	91% 10/11	1/1	2/3	2/2	1/1	2/2	1/1	1/1		

Comments:

8. The required elements were present and thoroughly completed for all but one investigation. For Individual #154 UIR 15-066, the item for identifying the staff involved was not in the UIR and, further, no staff were interviewed. The conclusion as to what happened (a fall) was derived solely from the individual's testimony. The fall occurred in the hall, so there should have been video evidence to validate the accidental nature of the fall. Further, the UIR noted that "this injury was witnessed by residential staff on the home." But there was nothing in the UIR to indicate that any of these staff were interviewed to corroborate the individual's testimony.

9. Nine of the investigations met criterion for this indicator. In addition to Individual #154 UIR 15-066, described above, Individual #346 UIR 15-051 named three staff as involved, but only two were interviewed. There was no explanation in the UIR as to why this third person was not interviewed.

10. Ten of the investigations met criterion for this indicator.

Outcome 7– Investigations are conducted and reviewed as required.											
			Individuals:								
#	Indicator	Overall Score	42	154	346	130	142	342	39		
11	Commenced within 24 hours of being reported.	100% 11/11	1/1	3/3	2/2	1/1	2/2	1/1	1/1		
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	82% 9/11	1/1	2/3	1/2	1/1	2/2	1/1	1/1		

13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	64% 7/11	0/1	1/3	1/2	1/1	2/2	1/1	1/1		

Comments:

12. Two facility-only investigations were completed more than 10 calendar days after reporting, with no approved extensions (Individual #346 15-051 12 days, Individual #154 15-066 11 days).

13. Supervisory review of four investigations did not identify problems with the reviews as required by this indicator (Individual #42 15-093, Individual #346 15-051, Individual #154 15-066 and 15-072). The expectation is that the facility's supervisory review process will identify the same types of issues that are identified by the Monitoring Team. In other words, a score of zero regarding late reporting or interviewing of all involved staff does not result in an automatic zero score for this indicator. Identifying, correcting, and/or explaining errors and inconsistencies contributes to the scoring determination for this indicator.

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.

			Individuals:								
#	Indicator	Overall Score	42	154	346	130	142	342	39		
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 2/2	N/A	N/A	N/A	1/1	N/A	1/1	N/A		
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 3/3	N/A	1/1	N/A	N/A	N/A	1/1	1/1		

Comments:

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.

			Individuals:								
#	Indicator	Overall Score	42	154	346	130	142	342	39		
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 11/11	1/1	3/3	2/2	1/1	2/2	1/1	1/1		
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 11/11	1/1	3/3	2/2	1/1	2/2	1/1	1/1		

18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 11/11	1/1	3/3	2/2	1/1	2/2	1/1	1/1		

Comments:
16-18. The Monitoring Team wishes to acknowledge the good work done by the IMC and her staff regarding this outcome and its three indicators.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	Yes									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No									
23	Action plans were appropriately developed, implemented, and tracked to completion.	No									

Comments:
19-23. In the previous report, the Monitoring Team wrote, "The San Antonio SSLC trend analysis was conducted at least quarterly, addressed minimum data elements, and provided a narrative explanation of the data." This continued to be the case.

The previous report also stated, "The facility provided data, but no analysis, related to allegations and incidents." This was now much improved: the QAQI Council meeting minutes reflected thoughtful analysis of data and include action plans to improve performance.

The Monitoring Team could see that action plans for corrective actions had been formulated, but very limited information was provided to demonstrate full development of the action plans, their implementation, and assessment of their effectiveness.

Thus, overall, there was much improvement, though additional work was still needed.

Psychiatry

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)											
			Individuals:								
#	Indicator	Overall Score	264	39	154	142					
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	25% 1/4	0/1	1/1	0/1	0/1					
48	Multiple medications were not used during chemical restraint.	50% 2/4	0/1	0/1	1/1	1/1					
49	Psychiatry follow-up occurred following chemical restraint.	75% 3/4	1/1	0/1	1/1	1/1					

Comments:

47. For three restraints, the psychiatry review was not completed in a timely manner.

48. In two restraints, three medications were used.

49. In the restraint for Individual #39, there was no documentation of psychiatric follow-up in the period of time following the episode.

Pre-Treatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.											
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	N/A									
	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. and b. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation or TIVA during the period under review. As discussed elsewhere, individuals who needed sedation to complete dental appointments experienced long delays in the scheduling of appointments with TIVA.

Outcome 9 – Individuals receive medical pre-treatment sedation safely.											
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									
Comments: None of the individuals that the Monitoring Team responsible for physical health reviewed received pre-treatment sedation for medical procedures in the six months prior to the review.											

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
			Individuals:								
#	Indicator	Overall Score									
1	If the individual received PTS in the past year for routine medical or dental procedures, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	N/A									
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	N/A									
3	Action plans were implemented.	N/A									
4	If implemented, progress was monitored.	N/A									
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A									
Comments: 1-5. None of the individuals reviewed were reported to have received PTS (at the facility) for routine medical or dental care for the time period reviewed by the Monitoring Team.											

Mortality Reviews

Outcome 10 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
			Individuals:								
#	Indicator	Overall Score	147	313	116	34	164	61			
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			

	completed within 14 days of the clinical death review.										
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	83% 5/6	1/1	1/1	1/1	1/1	0/1	1/1			
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	83% 5/6	1/1	1/1	1/1	1/1	0/1	1/1			
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	83% 5/6	1/1	1/1	1/1	1/1	0/1	1/1			
e.	Recommendations are followed through to closure.	33% 2/6	0/1	0/1	0/1	1/1	0/1	1/1			

Comments: a. Since the last review, six individuals died. The Monitoring Team reviewed all six of these deaths. The sixth individual died shortly before the Monitoring Team's onsite review, so complete mortality review and follow-up documentation was not yet available. Causes of death were listed as:

- For Individual #147, respiratory failure;
- For Individual #313, cardiac arrest, hypoxia, acute respiratory failure, and pneumonia;
- For Individual #116, septic shock, and sepsis due to urinary tract infection;
- For Individual #34, peritonitis;
- For Individual #164, acute renal failure due to pneumonia; and
- For Individual #61, chronic kidney disease, steatohepatitis, hypertension, and history of myocardial infarction.

e. The Medical Director submitted a number of packets showing the in-service training sessions that were done. However, overall, a number of recommendations were made, but there was no evidence that they were fully implemented and carried out to completion. Examples of recommendations not followed through to closure include:

- For Individual #164's mortality review, recommendations related to the IDTs' review of DNR/Hospice status of individuals, and the recommendation referred to the Dental Director;
- For Individual #116's mortality review, the recommendation for the Medical Compliance Nurse to develop a corrective action plan related to UTIs;
- For Individual #164's mortality review, there were missing signatures on the training roster for review and updates on diabetes guidelines; and
- For Individual #313's mortality review, based on documentation submitted, it did not appear all relevant Nursing Department staff had completed training on UTIs.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	ADRs are reported immediately.	N/A									
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A									
c.	Clinical follow-up action is taken, as necessary, with the individual.	N/A									
d.	Reportable ADRs are sent to MedWatch.	N/A									
Comments: a. through d. None of the individuals reviewed had adverse drug reactions reported, so these indicators were not reviewed.											

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	0% 0/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/2
Comments: a. and b. Since the last review, the Facility had not completed any DUEs.		

Domain #2: Using its policies, training, and quality assurance systems to establish and maintain compliance, the State will provide individuals in the Target Population with service plans that are developed through an integrated individual support planning process that address the individual's strengths, preferences, choice of services, goals, and needs for protections, services, and supports.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.

			Individuals:								
#	Indicator	Overall Score	94	346	142	342	253	209			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:

The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #142, Individual #94, Individual #346, Individual #342, Individual #253, and Individual #209. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the San Antonio SSLC campus. Six components of the ISP are monitored: recreation/leisure, relationships, employment/day, independence, living options, and health.

1. None of the individuals had a full array of individualized personal goals. Most goals were very broadly stated, contained generic outcomes, and were identical for many individuals. For example, the living option goal for four of the six individuals stated will live in the most integrated setting consistent with his/her preferences, strengths, and needs. Goals did not identify preferences for specific day activity or living options and, in many instances, did not offer an opportunity to learn new skills. For example, Individual #94's relationship goal stated "will maintain his current relationships." His recreation/leisure goal was to "enjoy his leisure time" and his goal for greater independences was to "increase his independence/self help skills."

2. Goals for individuals were not written in measurable terms, thus, it was not possible to determine if progress towards meeting goals had been achieved. Examples of personal goals that were not measurable included Individual #346's living option goal to work towards gaining skills to live out in the community, Individual #209's relationship goal to continue to build on relationships with others, Individual #253's relationship goal to be provided opportunities to participate in activities that strengthen relationships, and Individual #342's employment goal to increase vocational skills.

3. QIDPs reported that reliable and valid data were not available for most ISP action plans due to inconsistent implementation, lack of clear implementation and documentation methodology, and lack of inter-observer agreement. This was confirmed by a review of data implementation sheets and QIDP monthly reviews. Monthly reviews of services and supports noted gaps in implementation and data collection for all of the individuals. In some cases, it was noted that goals were never fully implemented during the ISP year. At the ISP Preparation meeting attended by the Monitoring Team for Individual #142, the IDT members reported that status on outcomes was unknown due to a lack of data documentation available to the team.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
			Individuals:								
#	Indicator	Overall Score	94	346	142	342	253	209			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
10	ISP action plans supported the individual's overall enhanced independence.	0% 0/5	0/1	0/1	0/1	0/1	0/1	N/A			
11	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	50% 3/6	0/1	1/1	0/1	1/1	0/1	1/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			

18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	2/6	0/6	1/6	0/6	0/6	2/6			

Comments:
Once San Antonio SSLC develops individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals and, thus, the facility can achieve compliance with this outcome and its indicators.

8. Personal goals were not well defined in the ISPs, as indicated above. Action plans were not developed to support goals that addressed risks or PNM goals (see additional comments for Risk outcome 4.d and PNM outcome 3.d).

9-10. Preferences and opportunities for choice were not well-integrated in the individuals' ISPs. Individuals had limited opportunities to learn new skills based on identified preferences. In most cases, there was no discussion regarding preferences for day programming. ISPs did not include discussion regarding opportunities for choice throughout the day. Individual #209's ISP was the exception. Supporting individuals to make choices and express preferences would be a first step in the IDT determining individual preferences for living options and day programming.

11. Without well-defined personal goals, it was difficult to determine if action plans would support the individuals to be more independent. Action plans to support independence were often not measurable, thus, it was unlikely that consistent implementation would occur. In some cases, action plans to support independence were based on skills that the individual had mastered. For example, Individual #142 had SAPS for toothbrushing and counting change. Assessments indicated that he had mastered these skills. Individual #94 had SAPs for brushing his teeth and paying the cashier. Assessments indicated that he had mastered these skills.

12. All individuals had an IHCP to address risks, however, supports to address risk were not typically integrated into other parts of the ISP. IDTs did not consistently integrate strategies to minimize risks in ISP action plans. For example, Individual #253 had a SAP for toothbrushing to address her risk for dental disease, however, the action plan did not integrate strategies to reduce her risk for aspiration while brushing. Individual #142's IDT failed to integrate strategies to address his risk for falls into his SAPs. In some cases, risk were identified through the IMRT process, but it was difficult to determine if they were then also addressed by the IDT because of the lack of documentation. For example, Individual #94 and Individual #346's ISPs listed incidents and injuries for the previous year, but did not document discussion regarding protections developed to address trends in incidents and/or injuries. As identified in Nursing outcome #4 scores, ISPs did not incorporate measurable objectives to address risks.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated. For example, behavioral recommendations were not integrated into teaching strategies in any of Individual #142 or Individual #346's SAPs. Communication and mobility recommendations were not integrated into Individual #94's or Individual #342's SAPs. Measurable objectives that would allow the IDT to track progress were not developed to address healthcare risks.

14. Overall, there was a lack of focus on specific plans for community participation that would have promoted any meaningful engagement or integration. One individual (Individual #209) had action plans that might support integration in the community through opportunities to visit with friends in the community, volunteering, and participation in a Job Club.

15. Action plans to support work and day programming did not address skills that were required for jobs or activities based on the individual's preferences. There was little consideration of what the individual wanted to learn or do during the day. Individuals did not have opportunities to explore employment options or learn work skills that might transfer into a more integrated setting. For example,

- For Individual #142, there was no discussion regarding jobs that he might prefer or find more interesting or challenging.
- Individual #94 had been bagging towels for at least two years at the sheltered workshop with no documented interest or progress. The IDT did not discuss work related to his preferences.
- Individual #253's IDT did not discuss day programming based on her preferences other than music activities. Although she had the opportunity to participate in music activities, this only comprised a small part of her day.

16. One individual (Individual #209) had substantial opportunities for functional engagement and was consistently engaged in functional activity during observations.

17. One of the ISPs addressed barriers to achieving goals. Documentation indicated that action plans and supports were not regularly implemented or monitored for any of the individuals. IDTs did not meet to discuss barriers to implementation. Individual #209's ISP noted that her behavior related to health risk was her greatest barrier to achieving her goals. The IDT integrated supports to address this barrier throughout her ISP.

18. For the most part, ISPs did not include collection of enough, or the right types of, data to make decisions regarding the efficacy of supports. SAPs often did not describe the behavioral objective. IHCP goals/objectives and interventions were often not measurable. IHCPs and many other action plans were written as staff actions without specific criteria.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
			Individuals:								
#	Indicator	Overall Score	94	346	142	342	253	209			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	1/6 17%	0/1	0/1	0/1	0/1	0/1	1/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	3/6 50%	0/1	0/1	1/1	1/1	1/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	4/6 67%	1/1	0/1	1/1	1/1	1/1	0/1			
23	The determination was based on a thorough examination of living	1/6	0/1	0/1	0/1	0/1	0/1	1/1			

	options.	17%									
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	4/6 67%	1/1	0/1	1/1	1/1	0/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	2/6 33%	0/1	1/1	0/1	0/1	0/1	1/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized measurable plans to educate the individual/LAR about community living options.	1/6 17%	0/1	0/1	0/1	0/1	0/1	1/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

19. One (Individual #209) of six ISPs included a description of the individual's preference and how that was determined.

21. Three of the six ISPs included recommendations from all relevant supports staff.

22. Four of the six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR.

23. One individual (Individual #209) had a thorough examination of living options based upon their preferences, needs, and strengths.

24. Four of the six ISPs identified a comprehensive list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed. Individual #346's ISP did not identify obstacles to referral. Individual #253's ISP indicated that needed medical supports were not available in the community, however, the IDT failed to identify which medical supports were not available.

26. Two of the ISPs included measurable action plans to address barriers to referral. Individual #346 and Individual #209's ISPs included measurable action plans to address behavior identified as a barrier to referral.

28. Five ISPs did not include action plans to educate individuals or LARs about community living options. It was clear that the team offered general information to all individuals and LARs on an annual basis. Information, however, did not include specific information on how the individual's preferences and needs might be supported in other living environments. IDTs should consider focusing on individualized options that are available and could support each individual's needs.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
			Individuals:								
#	Indicator	Overall Score	94	346	142	342	253	209			
30	The ISP was revised at least annually.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	67% 4/6	1/1	0/1	1/1	0/1	1/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

30. ISPs were revised every year.

32. ISPs were not fully implemented for any of the individuals.
    - Individual #142's QIDP monthly reviews indicated that his SAPs were not implemented April 2015 through June 2015. One SAP was implemented from July 2015 through September 2015.
    - Individual #94's QIDP monthly reviews indicated that action plans were not implemented within 30 days of ISP development and some had never been implemented.
    - Individual #346 and Individual #209's QIDP monthly reviews did not include data to support implementation within 30 days
    - Per QIDP monthly reviews, Individual #342's ISP was not implemented prior to August 2015.
    - Individual #253's QIDP monthly reviews indicated that her living option and relationship action plans had not been implemented.

33. Four of the six individuals attended their ISP meetings.

34. None of the individuals had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
			Individuals:								
#	Indicator	Overall Score	94	346	142	342	253	209			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	83% 5/6	1/1	1/1	1/1	0/1	1/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP Preparation meeting for five of the six individuals. ISP Preparation documentation was not submitted for Individual #342.

36. According to assessment submission data provided by the facility, one (Individual #342) of six individuals had all needed assessments available 10 days prior to the annual ISP meeting for planning purposes.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
			Individuals:								
#	Indicator	Overall Score	94	346	142	342	253	209			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			

Comments:

37. IDTs generally met when the individual experienced some type of regression or change in status, but they rarely used data to make decisions about revising the ISP. As noted throughout this report, consistent reliable data were not available to help teams determine if supports were effective and if the individual was making progress. It was not evident that IDT members regularly reviewed supports and took action as needed when individuals failed to make progress on outcomes or experienced regression.

38. QIDPs were not reviewing services and supports monthly. The Monitoring Team requested QIDP monthly reviews for the past six months for each individual. For one of the six individuals (Individual #253) there clear evidence that these reviews had been completed on a monthly basis. Based on interviews, QIDPs were generally knowledgeable of individuals' preferences, strengths, and needs, however, it was not evident that they took action when plans were not effective or not implemented.

Outcome 1 – Individuals at-risk conditions are properly identified.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	The IDT uses supporting clinical data when determining risks levels.	78% 14/18	2/2	2/2	1/2	1/2	1/2	2/2	2/2	2/2	1/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	56% 10/18	1/2	2/2	2/2	0/2	1/2	2/2	0/2	2/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #317 – respiratory compromise, and constipation/bowel obstruction; Individual #253 – skin integrity, and infections; Individual #281 – constipation/bowel obstruction, and gastrointestinal problems; Individual #209 – skin integrity, and infections; Individual #94 – seizures, and falls; Individual #54 – urinary tract infections (UTIs), and seizures; Individual #100 – infections, and skin integrity; Individual #87 – seizures, and falls; and Individual #142 – skin integrity, and falls).

a.i though a.iii. The IDTs that did not effectively use supporting clinical data and/or use the risk guidelines when determining a risk level were those for Individual #281 – gastrointestinal problems, Individual #209 – skin integrity, Individual #94 – falls, and Individual #142 – skin integrity.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, in a number of instances, when changes of status occurred that necessitated at least review of the risk ratings, IDTs did not review the IRRFs, and make changes, as appropriate, including for Individual #317 – constipation/bowel obstruction; Individual #209 – skin integrity, and infections; Individual #94 – falls; Individual #100 – infections, and skin integrity; and Individual #142 – skin integrity, and falls.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
4-7. Psychiatry-related goals for individuals were related to the reduction of problematic behaviors, such as aggression, self-injury, and unauthorized departure from the facility campus. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status.

All of the goals will need to be formulated in a manner that would make them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined. This will allow the psychiatrist to make data driven decisions regarding the efficacy of psychotropic medications.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
12	The individual has a CPE.	67% 6/9	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	100% 6/6	N/A	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1
14	CPE content is comprehensive.	17% 1/6	N/A	N/A	1/1	0/1	0/1	N/A	0/1	0/1	0/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	0% 0/2	N/A	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	56% 5/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1	0/1

Comments:
12-13. Six of the individuals had a CPE that was formatted as required by the Settlement Agreement. No individuals had a CPE completed recently. One individual had an evaluation in 2012, three individuals had evaluations done in 2013, and two individuals had evaluations done in 2014.

14. The Monitoring Team looks for 14 components to be in the CPE. Individual #154's CPE had all of the required components. The others were missing from one to three components, most often missing was a good bio-psycho-social formulation.

16. Criterion was met for five individuals. For the other four, diagnoses were not consistent when comparing the psychiatric documentation and medical assessments.

Outcome 5 – Individuals' status and treatment are reviewed annually.

			Individuals:								
	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
17	Status and treatment document was updated within past 12 months.	25% 2/8	0/1	N/A	0/1	0/1	0/1	1/1	0/1	0/1	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/2	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

17. Individual #42 had not been residing in the facility long enough to require an updated evaluation. Reviews were completed for Individual #142 and Individual #39. For the others, there were no reviews or they were more than 12 months old.

18. The Monitoring Team scores 16 aspects of the annual document. For the two that were completed, many aspects were missing.

21. There was a need for improvement with regard to the documentation of the ISP discussion to include the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective and the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side effects of the medication in addition to the benefits. The Monitoring Team looks for the above noted aspects of psychiatry participation. There was an overall need for improvement with regard to the ISP with specific focus on the integration of psychiatry with other clinical disciplines.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 22. No individuals had a PSP.											

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	33% 3/9	0/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1
29	The written information provided to individual and to the guardian was adequate and understandable.	33% 3/9	0/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1
30	A risk versus benefit discussion is in the consent documentation.	33% 3/9	0/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	44% 4/9	0/1	0/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1
Comments: 28-30. Psychiatry has recently assumed responsibility for the informed consent process. In the three cases where new consent forms were utilized, documentation met criterion for these indicators. 31. There was a need for improvement with regard to reference to alternate and non-pharmacological interventions. One issue may be that this information was not implicitly required when completing the consent form. 32. HRC documentation was provided for four individuals. HRC review is required prior to the initiation of medication and annually.											

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 13/13	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

1. Of the 16 individuals reviewed by both Monitoring Teams, 13 required a PBSP (nine of the individuals reviewed by the behavioral health Monitoring Team and four individuals reviewed by the physical health Monitoring Team). Individual #264 had a PBSP at the time of the onsite review, however, dangerous behavior required her to have three restraints in March 2015, one in April 2015, two in June 2015, and one in July 2015 before she had a PBSP in August 2015. Therefore, although she had a PBSP at the time of the onsite review, she did not have one for the previous five months, despite her dangerous behavior.

4. Individual #154's psychiatric and behavioral progress notes, ISPA, etc., indicated that she engaged in physical aggression. Some incidents of physical aggression were severe enough to provoke protective restraints in March 2015 and September 2015, however, her PBSP did not target physical aggression.

5. The facility had recently begun to collect monthly interobserver agreement (IOA) and data timeliness. At the time of the onsite review, however, no individuals had both IOA and data collection timeliness data and, therefore, the PBSP data were not rated as reliable.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
10	The individual has a current, and complete annual behavioral health update.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

10. All nine individuals had annual behavioral health assessments that were revised within the last 12 months. Two (Individual #342, Individual #39), however, did not contain an assessment or review of intellectual ability.

11-12. It was encouraging to find that all nine individuals had both current and complete functional assessments. The Monitoring Team found Individual #39's functional assessment to be particularly good.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	44% 4/9	0/1	1/1	1/1	1/1	0/1	0/1	1/1	0/1	0/1
14	The PBSP was current (within the past 12 months).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

13. Five (Individual #94, Individual #130, Individual #142, Individual #342, and Individual #39) of the nine PBSPs did not have documentation of implementation within 14 days of attaining necessary approvals.

14-15. All nine of the PBSPs were current and eight were complete. The exception, Individual #94's PBSP, was rated as incomplete because the replacement behavior appeared to be reinforced only in the day program. The Monitoring Team found Individual #39, Individual #130, and Individual #346's PBSPs to be particularly clear and thorough.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 2/2	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 2/2	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1
Comments: 24-25. Individual #142 and Individual #39 were referred and received counseling services. Both treatment plans and progress notes were complete.											

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	75% 6/8	0/1	0/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
c.	Individual has timely quarterly reviews for the three quarters in which an annual review has not been completed.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
f.	Individual receives quality quarterly medical reviews.	33% 3/9	0/1	1/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1
Comments: d. Problems varied across medical assessments. However, in all of the medical assessments reviewed, two to seven components were missing, incomplete, or inaccurate. As applicable to the individuals reviewed, all annual medical assessments described past medical histories, included allergies or severe side effects of medications, and included lists of medications with dosages at the time of the AMA. Moving forward, the Medical Department should focus on ensuring medical assessments include pre-natal											

histories, family history, social/smoking histories, childhood illnesses, interval histories, pertinent laboratory information, complete physical exams with vital signs, updated active problem lists, and plans of care for each active medical problem, when appropriate.

Of particular note, the family histories were often incomplete and frequently stated that the parents and siblings were "normal." The family history should specifically address relevant history, such as diabetes mellitus, hypertension, cardio vascular disease, cancer, kidney disease, asthma, mental illness and other conditions with known familial patterns and genetic links.

e. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. It was good to see that clinical justification was present for the diagnoses reviewed.

f. In a number of cases, individuals did not have up-to-date quarterlies, so this indicator was marked "0." In fact, four individuals had not had quarterly assessments completed in over a year, and a fifth individual had not had a quarterly completed since February 2015. It was quite concerning that in its comments on the draft report, the State questioned this finding for these individuals.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.

			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	61% 11/18	0/2	0/2	2/2	2/2	1/2	2/2	2/2	0/2	2/2

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #317 – gastrointestinal problems, and osteoporosis; Individual #253 – infections, and skin integrity; Individual #281 – aspiration, and osteoporosis; Individual #209 – cardiac disease, and weight; Individual #94 – falls, and seizures; Individual #54 – seizures, and UTIs; Individual #100 – osteoporosis, and seizures; Individual #87 – seizures, and other: hyperprolactinemia; and Individual #142 – seizures, and osteoporosis).

The ISPs/IHCPs that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition were those for Individual #281 – aspiration, and osteoporosis; Individual #209 – cardiac disease, and weight; Individual #94 - seizures; Individual #54 – seizures, and UTIs; Individual #100 – osteoporosis, and seizures; and Individual #142 – seizures, and osteoporosis.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	100% 1/1	N/R	N/A	N/A	N/R	N/A	N/A	1/1	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	50% 3/6		1/1	0/1		1/1	0/1	N/A	1/1	0/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	33% 2/6		1/1	1/1		0/1	0/1	N/A	0/1	0/1
b.	Individual receives a comprehensive dental examination.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	0% 0/6	N/R	0/1	0/1	N/R	0/1	0/1	N/A	0/1	0/1

Comments: Because Individual #317 and Individual #209 were a part of the outcome sample, and were at low risk for dental, some indicators were not rated for them (i.e., the "deeper review" indicators).

b. Dental exams included the following:

- A description of the individual's cooperation;
- Information about oral cancer screening;
- A description of treatment provided;
- The recall frequency; and
- Treatment plans.

However, dental exams were missing one or more of the following:

- An oral hygiene rating completed prior to treatment;
- Information about the individual's last x-rays and the type of x-rays;
- Periodontal charting;
- A description of periodontal condition;
- An odontogram;
- The number of teeth present/missing;
- Caries risk; and
- Periodontal risk.

c. All of the dental summaries were missing one or more of the required elements, and for some individuals, Facility staff submitted no annual dental summary (i.e., Individual #94, and Individual #54). Moving forward, the Facility should focus on ensuring dental summaries include the following:

- Recommendations related to the need for desensitization or other plan;
- The number of teeth present/missing;
- Effectiveness of pre-treatment sedation;
- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health;
- Provision of oral hygiene instructions to staff and the individual;
- Recommendations for the risk level for the IRRF;
- Dental care recommendations;
- Treatment plan, including the recall frequency; and
- A description of the treatment provided.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	Individuals have timely nursing assessments:										

	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	88% 7/8	1/1	1/1	1/1	0/1	1/1	1/1	N/A	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	20% 2/10	0/2	2/2	N/A	0/2	0/1	N/A	0/1	0/1	0/1

Comments: b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #317 – respiratory compromise, and constipation/bowel obstruction; Individual #253 – skin integrity, and infections; Individual #281 – constipation/bowel obstruction, and gastrointestinal problems; Individual #209 – skin integrity, and infections; Individual #94 – seizures, and falls; Individual #54 – urinary tract infections (UTIs), and seizures; Individual #100 – infections, and skin integrity; Individual #87 – seizures, and falls; and Individual #142 – skin integrity, and falls).

The annual comprehensive nursing assessments did not contain reviews of individuals' risks that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

c. Nursing assessments generally were not completed in accordance with nursing protocols or current standards of practice for individuals' changes of status. The exceptions were for Individual #253 for cellulitis in the left foot, and cellulitis of the face (i.e., skin integrity and infections).

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.

			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	The individual has an ISP/IHCP that sufficiently addresses the health	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0/18									
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. through f. Problems seen across most IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals' specific health care needs; a lack of focus on preventative measures (on a positive note, Individual #87's IHCP related to falls did include preventative measures); a lack of measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working); a lack of action steps that supported the goal/objective; a lack of specific clinical indicators to be monitored; and lack of identification of the frequency for monitoring of the individuals' health risks.										

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	33% 2/6	1/1	1/1	N/A	N/A	0/1	0/1	0/1	N/A	0/1

b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	33% 2/6	1/1	1/1			0/1	0/1	0/1		0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	40% 2/5	1/1	0/1			1/1	0/1	N/A		0/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	33% 2/6	1/1	0/1			1/1	0/1	0/1		0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	0% 0/4	0/1	0/1	0/1		N/A	N/A	0/1		N/A
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	33% 2/6	1/1	0/1	N/A		1/1	0/1	0/1		0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/6	0/1	0/1			0/1	0/1	0/1		0/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5	0/1	0/1			0/1	0/1	N/A		0/1

Comments: a. through d., and f. For the six individuals that should have been referred to the PNMT:

- Individual #317 was referred to the PNMT within five days of the qualifying event, and the PNMT conducted a review within five days. The PNMT then conducted a comprehensive assessment in a timely manner.
- Individual #253 was referred timely to the PNMT for "increased concerns due to declining ability to swallow during medication administration and meals," and the PNMT conducted a review within five days. The PNMT determined that only review and investigative supports were indicated due to report that there was an aspiration event while hospitalized but no aspiration pneumonia. However, the rationale for not completing a comprehensive assessment was not well documented. Recommended actions included oral motor interventions, a modified barium swallow study (MBSS), staff training related to medication administration, adjustments to the Head of Bed Evaluation, and actions to address skin integrity issues. The MBSS completed in 7/15 indicated that she was at high risk of aspiration of thin liquids. This individual's increasing complexity appeared to require a comprehensive assessment.
- Individual #94 was not referred to the PNMT timely (i.e., not until 9/4/15) despite 30 falls in the previous six months. Once he was referred, the PNMT completed a comprehensive assessment within 30 days.
- On 6/29/15, Individual #54 reportedly choked on eggs, but there was no evidence the PNMT conducted a review related to the

incident on this date (i.e., there was review of another choking event on 12/5/14). As indicated in the audit tool interpretive guidelines, recurrent choking (i.e., two episodes in 12 months) is a trigger for PNMT review. The doctor's note referred to the most recent event as a "choking event cleared by patient without intervention." The therapist's note described it as a "near choking event." The PNMT documentation submitted indicated that the choking event in December 2014 required abdominal thrusts six times. The PNMT should have conducted at least a review.

- For Individual #100, there was no evidence of full PNMT review when he met the threshold of six falls within 60 days (i.e., he had at least 10 documented falls between 4/5/15 and 7/15/15). Between February and April 2015, he had six falls in 60 days with another four falls in May, but the first PNMT review was documented on 6/4/15. The documentation included no review of root cause, and the only recommendation was to verify in-service training of night shift staff. Although in its comments on the draft report, the State indicated this was a staff compliance issue, no evidence was found in the documentation to support this claim, other than a statement that pulled staff were involved in the majority of his falls. On 6/11/15, he was discharged from PNMT discussion. Five additional falls occurred in June and July, so the PNMT reviewed him again on 7/23/15. The only recommendation was for the Habilitation Therapy Director to communicate with the Unit Director to problem-solve. On 7/22/15, he fell and hit his eye. He was assigned a one-to-one staff with no pulled staff. Then, three more falls occurred in August, and one in September. Documentation indicated it was a compliance issue, but no data was presented to substantiate this theory. For example, no evidence was found to show that the PNMT conducted observations or monitored staff compliance with the PNMP. Individual #100's guardian expressed concern about his posture, and the PT was to investigate (per PNMT minutes 10/1/15). However, no evidence was submitted that this occurred. Overall, there was insufficient review and insufficient documentation for Individual #100.
- Individual #142 had six falls recorded from 4/5/15 to 5/17/15, and again from 5/8/15 to 7/15/15, and his falls continued. At the ISP Preparation meeting the Monitoring Team attended during the week of the onsite review, IDT members reported that he had experienced another six falls in the last month and there was still no referral to the PNMT.

e. The PNMT did not review the RN Post Hospitalization review until two weeks after Individual #317's two back-to-back hospitalizations. In its response to the draft report, the State indicated that PNMT members were at an ISPA meeting the IDT held two days after Individual #317's hospitalization at which the RN Post-Hospitalization review was discussed. However, the Facility had not provided the Monitoring Team with a copy of the ISPA. Although this appeared to be a documentation issue, the Monitoring Team was unable to confirm it with the documents provided. An RN Post Hospitalization review was not completed after Individual #253's May 2015 hospitalization. Although a review was completed for Individual #281, the PNMT did not review it. For Individual #100, the RN note did not offer any recommendations or referral for PNMT follow-up, but should have.

h. For Individual #253, Individual #54, and Individual #142, the PNMT should have conducted comprehensive assessments, but did not. For the two comprehensive assessments that were completed, problems varied. With one or both, the following components were missing or incomplete:

- Presenting problem;
- Discussion of medications that might be pertinent to the problem, and discussion of relevance to PNM supports and services;
- Identification of the potential causes of the individual's physical and nutritional management problems;
- Recommendations, including rationale, for physical and nutritional interventions; and
- Recommendations for measurable goals/objectives, as well as indicators and thresholds.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	11% 2/18	0/2	0/2	1/2	0/2	1/2	0/2	1/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	22% 4/18	0/2	0/2	1/2	1/2	1/2	0/2	1/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	78% 7/9	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	6% 1/18	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	11% 2/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	1/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	6% 1/18	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included goals/objectives related to: aspiration, and respiratory compromise for Individual #317; aspiration, and skin integrity for Individual #253; aspiration, and falls for Individual #281; falls, and choking for Individual #209; choking, and falls for Individual #94; choking, and falls for Individual #54; aspiration, and falls for Individual #100; falls, and choking for Individual #87; and falls, and fractures for Individual #142.

a. ISPs/IHCPs reviewed generally did not sufficiently address individuals' PNM needs. Overall, many action steps, including strategies and interventions were missing, and the etiology of the issue often was not addressed. The exceptions were the IHCPs for choking for Individual #94, and aspiration for Individual #100.

b. IHCPs reviewed often did not include preventative measures to minimize the individual's condition of risk. Those that did were falls for Individual #281, falls for Individual #209, choking for Individual #94, and aspiration for Individual #100.

d. Most of the IHCPs did not identify the actions steps necessary to meet the identified objectives. Although Individual #318's IHCP for respiratory compromise included action steps to meet the identified goal/objective, the goal was not clinically relevant.

e. None of the IHCPs reviewed identified the necessary clinical indicators.

f. IHCPs reviewed that defined individualized triggers, and actions to take when they occur were those for choking for Individual #54, and falls for Individual #87.

g. The IHCP that defined the frequency of monitoring was the one for respiratory compromise for Individual #317.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	50% 1/2	1/1		0/1						
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/1	N/A		0/1						
Comments: a. Clinical justification for total or supplemental enteral nutrition was found in the IRRF and OT/PT assessments for one of the two individuals reviewed. b. For Individual #281, the IDT discussed the potential to begin bolus feedings, but did not develop a plan to address it.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	Individual receives timely screening and/or assessment:		N/R								

	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	100% 1/1							1/1		
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	100% 1/1							1/1		
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	50% 4/8		0/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	50% 4/8		0/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/3		N/A	N/A	N/A	0/1	N/A	0/1	0/1	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	20% 1/5		0/1	0/1	0/1	N/A	1/1	N/A	N/A	0/1
	Comments: a. and b. Four of the nine individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. The following concerns were noted:										

- Individual #253 was hospitalized for cellulitis on her right arm, but there was no evidence that an OT/PT followed up in relation to her arm. In its response to the draft report, the State indicated: "the cellulitis for Individual #253 was not related to pressure or positioning and was treated medically with antibiotics and anti-fungal medications. OT/PT assessment was not necessary since this was a medical issue and Individual #253 already required total staff assistance for all areas of personal care, transfers, bed mobility and all positioning (so her plan of care would not have changed)." At a minimum, OT/PT should have reviewed the PNMP, and if the cellulitis was not related to positioning and no specialized positioning was indicated, stated this.
- For Individual #94, no evidence was found of an OT/PT assessment, even though the assessment information was noted in the ISP, dated 6/23/15. In addition, there was no evidence that the IDT PT followed-up with the individual despite numerous falls, except on 8/5/15 (i.e., the PNMT PT wrote a note). The OT in conjunction with the SLP did follow up on a coughing incident at breakfast on 7/30/15, and a near choking incident on 8/3/15.
- For Individual #100, the OT and PT completed a comprehensive assessment rather than a screening to establish baseline, which was an appropriate approach. However, there was no evidence that the OT/PT conducted any follow-up related to frequent falls prior to the involvement of the PNMT, and there was no evidence that the OT/PT conducted post-hospitalization assessments.
- Individual #142 had an Evaluation Update completed, but there was no evidence that the OT/PT conducted additional review related to continued falls over the last two years.

d. and e. The quality of Comprehensive Assessments and Evaluation Updates varied widely. On a positive note, the OT and PT that completed the Evaluation Update for Individual #54 did a thorough and thoughtful job, and the resulting assessment document provided the IDT with good information and recommendations that took into consideration the individual's preferences, strengths, and needs. As noted above, for Individual #94, the Facility did not provide a copy of an assessment. The remaining updates and assessments were missing elements or problems were noted with one or more of the necessary elements. Moving forward, the Facility should focus on ensuring that, based on the individual's preferences, strengths, and needs, assessments and updates address and/or provide updates on the following:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; and

- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.

			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	38% 3/8	NR	0/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	88% 7/8		1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	40% 2/5		0/1	1/1	N/A	1/1	0/1	N/A	0/1	N/A
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: c. Individual #253's OT/PT assessment recommended direct therapy and in the narrative of the ISP, the IDT approved it, but this was not reflected in the ISP action plans. Similarly, Individual #54's direct therapy plan for walking/standing was not included in the ISP, and elbow range of motion was identified as a need in Individual #87's assessment information that was reproduced in the ISP, but the ISP did not document IDT discussion, and no plan was included in the ISP action plan section.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.

			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	Individual receives timely communication screening and/or assessment:										

	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	N/A	N/A	N/A	N/R	N/A	N/A	1/1	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	86% 6/7	1/1	1/1	1/1		1/1	0/1	1/1	1/1	N/A
b.	Individual receives assessment in accordance with their individualized needs related to communication.	88% 7/8	1/1	1/1	1/1		1/1	0/1	1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	0% 0/1	N/A	N/A	N/A		N/A	N/A	0/1	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/3	0/1	0/1	N/A		N/A	0/1	N/A	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/3	N/A	N/A	0/1		0/1	N/A	N/A	0/1	N/A
Comments: a. and b. Individual #142 received a comprehensive communication assessment in 2013, which did not recommend supports due to his functional communication skills. Its timeliness and quality were not assessed as part of this review, due to it being completed in 2013. Individual #100's screening indicated that he had sufficient functional communication skills, and he did not require further assessment or services.											

d. and e. Problems varied across comprehensive assessments and updates, but in all assessments and updates reviewed, one or more of the key components were insufficient to address the individual's strengths, needs, and preferences. Based on the problems identified in the assessments and updates reviewed, moving forward, the Facility should ensure communication assessments and updates address, and/or include updates, as appropriate, regarding:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- The individual's preferences and strengths are used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services
- Functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- A comparative analysis of current communication function with previous assessments;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.

			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	25% 2/8	0/1	0/1	0/1	N/R	0/1	0/1	1/1	1/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/4	0/1	0/1	0/1		0/1	N/A	N/A	N/A	N/A
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	86% 6/7	1/1	1/1	1/1		1/1	0/1	1/1	1/1	N/A

d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a. At times, individuals' communication assessments included valuable descriptions of how they communicated that were not included in the ISPs (e.g., Individual #317, and Individual #253). For Individual #54, the content in the ISP indicated that his most recent Comprehensive Assessment was in 2012. Since no current assessment was submitted for review, it could not be determined if the information in the ISP was based on current assessment or not.

b. Individual #94 did not have a Communication Dictionary, but should have due to reported limitations in verbal skills.

c. For Individual #54, due to the fact that the communication assessment was not available at the time of the ISP meeting, it was not clear that the strategy included in the ISP was based on updated assessment information.

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.

			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	85% 22/26	3/3	2/2	3/3	3/3	3/3	1/3	1/3	3/3	1/3
3	The individual's SAPs were based on assessment results.	96% 25/26	3/3	2/2	3/3	3/3	3/3	2/3	3/3	3/3	3/3
4	SAPs are practical, functional, and meaningful.	19% 5/26	1/3	0/2	1/3	2/3	0/3	1/3	0/3	0/3	0/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	8% 2/26	1/3	0/2	0/3	0/3	0/3	1/3	0/3	0/3	0/3

Comments:

1. All nine individuals had skill acquisition plans (SAPs).

2. The Monitoring Team chooses three current SAPs for each individual for review. Only two SAPs were available for review for Individual #42 for a total of 26 for this review. Eighty-five percent of the SAPs were judged to be measurable (e.g., Individual #342's sign break SAP). The four SAPs that were judged not be measurable had a discrepancy in the behavioral objective and the SAP data sheet. For example, the behavioral objective for Individual #264's make a purchase SAP stated that it needed to be done with one

verbal prompt for one of one trial a month. The SAP data sheet, however, indicated that there will be four trials conducted a month.

3. The Monitoring Team was encouraged that 96% percent of the SAPs were clearly based on assessment results. For example, Individual #94's OT assessment indicated that he was independent in all aspects of dining except opening his milk carton. Learning to open his milk carton would allow him to be independent and enhance his fine motor skills, therefore, an open the milk carton SAP was developed. Individual #142's functional skills assessment, on the other hand, indicated that he could brush his teeth, therefore, his toothbrushing SAP was rated as not based on assessment results.

4. Five SAPs appeared to be practical and functional (e.g., Individual #94's open his milk carton SAP). The SAPs that were judged not to be practical or functional typically appeared to represent a compliance issue rather than a new skill (e.g., Individual #142's complete work SAP).

5. None of the 26 SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. Additionally, several SAP data sheets indicated that the data were not reliable (e.g., Individual #154's sort laundry SAP), others had missing data (e.g., Individual #142's brush teeth SAP), and in others SAP data reported in the monthly QIDP report was inconsistent with raw data sheets (e.g., Individual #264's come to the medication area SAP). The facility recently began to assess IOA, however, there was no documentation of IOA for any of the SAPs at the time of the onsite review. The Monitoring Team observed several SAPs being implemented and found that two of the SAPs (Individual #142's complete work SAP, Individual #94's brush teeth SAP) were scored correctly and, therefore, were scored as having reliable data, despite the absence of reliability data. The best way to ensure that SAP data are reliable is to regularly assess interobserver reliability (IOA), and assure that accurate data are reported in the QIDP monthly report.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.

			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
10	The individual has a current FSA, PSI, and vocational assessment.	44% 4/9	0/1	1/1	0/1	0/1	1/1	0/1	0/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
12	These assessments included recommendations for skill acquisition.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
10-12. Four individuals had current FSAs, PSIs, and vocational assessments. The others had late annual vocational updates (e.g., Individual #154). Additionally, none of the individuals had documentation that FSAs (e.g., Individual #39), PSIs (no documentation available), and vocational assessments (e.g., Individual #346) were available to the IDT at least 10 days prior to the ISP. It was encouraging, however, to find that all the FSAs and vocational assessments included SAP recommendations.

Domain #3: Individuals in the Target Population will achieve optimal physical, mental, and behavioral health and well-being through access to timely and appropriate clinical services.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
			Individuals:								
#	Indicator	Overall Score	154	130	264	39					
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	100% 4/4	1/1	1/1	1/1	1/1					
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 4/4	1/1	1/1	1/1	1/1					
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 4/4	1/1	1/1	1/1	1/1					
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 4/4	1/1	1/1	1/1	1/1					
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	50% 2/4	1/1	1/1	0/1	0/1					
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address	100% 4/4	1/1	1/1	1/1	1/1					

	them.										
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	75% 3/4	1/1	1/1	0/1	1/1					
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	50% 2/4	0/1	1/1	0/1	1/1					
26	The PBSP was complete.	N/A	N/A	N/A	N/A	N/A					
27	The crisis intervention plan was complete.	100% 3/3	N/A	1/1	1/1	1/1					
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	75% 3/4	0/1	1/1	1/1	1/1					
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	100% 4/4	1/1	1/1	1/1	1/1					

Comments:
This outcome and its indicators applied to Individual #154, Individual #130, Individual #264, and Individual #39.

18-19. All individuals that had more than three restraints in 30 days had ISPAs to address those restraints within 10 business days. Additionally, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.

20. All ISPAs following more than three restraints in 30 days had discussions of potential adaptive skills, and biological, medical, and/or psychosocial issues, and actions to address them in the future.

21. All ISPAs following more than three restraints in 30 days reflected a discussion of contributing environmental variables, and if any were hypothesized to be relevant, a plan to address them.

22. All of the ISPAs included a discussion of potential antecedents contribution to each individual's restraints. Individual #264 and Individual #39's ISPAs, however, did not reflect a discussion of plans or action to address those antecedents in the future.

23. All of the ISPAs reflected a discussion among the IDT of potential variables (e.g., gaining access to tangible reinforcers) maintaining the dangerous behavior provoking each individual's restraints, and if any were hypothesized to be relevant, a plan to address them.

24. Individual #264's fourth restraint occurred in May 2015, however, she did not have a PBSP until August 2015.

25. Individual #154 did not have a CIP. She did appear to require one because she had two restraints in March 2015, and five more in

September 2015 and the ISPA did not describe a specific unique event that occasioned Individual #154's restraints. Additionally, Individual #264's fourth restraint occurred in May 2015, however, she did not have a CIP until August 2015. As specified in the interpretive guidelines for the monitoring of this indicator, individuals who have had more than three restraints in any rolling 30-day period should have a CIP, unless the IDT has documented that the restraints were the result of a unique and temporary situation, such as a toothache. Both of these individuals had multiple restraints and neither of their ISPAs suggested that these represented unique situations.

27. Individual #130, Individual #264, and Individual #39's CIPs were complete.

28. All four individuals with more than three restraints in 30 days had treatment integrity data. Individual #154's, however, indicated that her PBSP was not implemented as written.

29. All individuals ISPA's addressing more than three restraints in 30 days, indicated that the IDT reviewed, and revised when necessary, their PBSP.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
1	If not receiving psychiatric services, a Reiss was conducted.	100% 3/3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 1. For the 16 individuals reviewed by both Monitoring Teams, all but three of the individuals were receiving psychiatric services. These three individuals all received Reiss Screens and further evaluation was not necessary.											

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
8	The individual is making progress and/or maintaining stability.	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

		0/9									
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	56% 5/9	1/1	0/1	0/1	1/1	0/1	0/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	56% 5/9	1/1	0/1	0/1	1/1	0/1	0/1	1/1	1/1	1/1

Comments:
8-9. This outcome is concerned with the individual's general clinical status and stability. Without measurable goals and objectives, progress could not be determined. Thus, the first two indicators were scored at 0%.

10-11. Despite the absence of measurable goals it was apparent that, in general, when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments) were developed and implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
23	The derivation of the target behaviors was consistent in both the structural/ functional behavioral assessment and the psychiatric documentation.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	The psychiatrist participated in the development of the PBSP.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
23. There were concerns regarding the validity of target symptoms identified. In general, the target symptoms did not correspond with a specific diagnosis.

24. There was no indication of psychiatrist participation in any aspects of the development of the PBSP. PBSP documents revealed that psychiatric documentation was cut and pasted into the final report. There was not evidence of psychiatric participation outside of the inclusion of this information.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	33% 2/6	0/1	0/1	N/A	1/1	N/A	0/1	0/1	N/A	1/1
26	Frequency was at least annual.	50% 3/6	1/1	0/1	N/A	1/1	N/A	0/1	0/1	N/A	1/1
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	33% 2/6	0/1	0/1	N/A	1/1	N/A	0/1	0/1	N/A	1/1
Comments: 25-27. These indicators applied to six of the individuals. The facility had developed a combined clinic, where individuals were seen by neurology with psychiatrist participating in the clinic.											

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
33	Quarterly reviews were completed quarterly.	78% 7/9	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 3/3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 33. Individual #142 and Individual #42 did not have one or more quarterly reviews conducted on time over the past year. 34. The Monitoring Team looks for nine components to have occurred during the quarterly reviews. In general, reviews were missing from one to six components. Missing from every review was a review of the implementation of non-pharmacological interventions. 35. While psychiatry clinic was not observed for the individuals reviewed by the Monitoring Team, other psychiatry clinical encounters were observed during the monitoring visit. These were for Individual #262, Individual #47, and Individual #347. In general, the psychiatry clinic was thorough and detailed, including a review of the pertinent laboratory examinations, other assessments, and data when available. These psychiatry clinics met criterion for this indicator.										

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	56% 5/9	1/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1	0/1
Comments: 36. In general, these assessments were performed in a timely manner and reviewed by the psychiatrist within 15 days. There were some delays in psychiatrist review for four individuals, likely due to inconsistent psychiatric staffing.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
37	Emergency/urgent and follow-up/interim clinics were available if needed.	50% 4/8	N/A	0/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	50% 4/8	N/A	0/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	50% 4/8	N/A	0/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1
Comments: 37-39. There was a need for more frequent psychiatric reviews for some individuals. There were some delays, likely due to inconsistent and insufficient psychiatric staffing. Provision of emergency and interim psychiatry clinics should be one of the priorities for the department in the future.											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication	0%	N/A	N/A	0/1	N/A	N/A	N/A	0/1	N/A	0/1

	administration (PEMA), the administration of the medication followed policy.	0/3									

Comments:
40-41. There was no indication that the facility used psychotropic medication to sedate individuals for the convenience of staff or for punishment. There were two individuals (Individual #154, Individual #342) who had either high doses of medication and/or multiple medication changes, and there was cause for concern that medication was being used as a substitute for treatment. In both of these cases, the individual's treatment plan should be reassessed.

43. Three individuals (Individual #264, Individual #154, Individual #39) received PEMA. In all three of these cases, documentation indicated that the medication administration was actually a chemical restraint (implemented in a behavioral crisis) and should have been coded as such.

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.

			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	43% 3/7	0/1	0/1	0/1	1/1	1/1	0/1	N/A	N/A	1/1
45	There is a tapering plan, or rationale for why not.	14% 1/7	0/1	0/1	0/1	1/1	0/1	0/1	N/A	N/A	0/1
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	0% 0/7	0/1	N/A	0/1	0/1	0/1	0/1	N/A	N/A	0/1

Comments:
44-45. These indicators applied to seven individuals. When polypharmacy justification was documented, the justification was cogent and appropriate. As there has been inconsistent psychiatric staffing and a paucity of psychiatric resources, justification was not located in all records.

46. The facility had not had a polypharmacy committee meeting since prior to the previous monitoring visit.

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
6	The individual is making expected progress	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
9	Activity and/or revisions to treatment were implemented.	50% 3/6	1/1	0/1	1/1	0/1	1/1	N/A	N/A	0/1	N/A

Comments:

6. Psychology indicators #2-5 need to be scored 1 in order for this indicator to be scored 1. There is, however, one exception. That is, if the facility did not collect data timeliness, but all other aspects show that the data are reliable (i.e., IOA was collected by facility, it had good scores, the Monitoring Team's own observations of data timeliness were good, and the data showed progress), this indicator can be scored 1 even if indicator #5 is scored 0. Details regarding data reliability are in indicator #5 of this report.

A determination of progress was not possible for Individual #264 because her PBSP was recently developed and she had less than three months of data to review. For the others, problems with the reliability of the data precluded making a determination of their progress.

The facility's progress note data for the eight individuals with PBSP data suggested that only two, Individual #39 and Individual #142, were progressing at the time of the review. Individual #130 was the only individual with IOA in the last six months, however, her data indicated she was not progressing.

7. Individuals were noted to not be making progress. Individual #94, Individual #130, and Individual #154's progress notes suggested actions to address their lack of progress. For example, Individual #130's note suggested that PBSP be revised and a behavioral contract be added to address her absence of progress. Individual #42, Individual #346, and Individual #342's progress notes, however, did not address suggested actions to be taken to address their lack of progress.

9. There was evidence that Individual #94's, Individual #130's, and Individual #154's action in their progress notes was implemented.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 16. None of the nine individual's treatment sites had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) implementing PBSPs were in fact trained on their PBSPs. 17. San Antonio SSLC utilized a brief PBSP for all individuals for DSPs. 18. All functional assessments and PBSPs were written by a behavioral specialist who was enrolled in, or had completed BCBA coursework, and all were signed off by a BCBA.											

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
19	The individual's progress note comments on the progress of the individual.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	44% 4/9	0/1	0/1	1/1	1/1	1/1	0/1	1/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five	100%									

	different individuals, in the past six months.		

Comments:
20. All individuals had graphed PBSP data. Individual #94, Individual #342, and Individual #39's graphs, however, did not note important environmental changes (e.g., medication changes), Individual #42's graph contained multiple data paths that made visual interpretation of the data difficult, and Individual #142's graph was both difficult to interpret and did not note important environmental changes.

21. None of the individuals were seen in psychiatry clinic during the onsite review. In order to score this indicator, the Monitoring Team observed Individual #262's psychiatric clinic meeting, and found that current data were presented and graphed, which encouraged data based decisions by the IDT.

22-23. None of the individuals had a peer review meeting during the onsite review. In order to score this indicator, the Monitoring Team observed Individual #338's peer review. Individual #338 was reviewed because she had not been progressing as expected. Her peer review included the review of her functional assessment, PBSP, and progress notes. There was participation and discussion by the behavioral health services team to improve her PBSP. Additionally, San Antonio SSLC had documentation that internal peer review meetings were consistently occurring weekly, and external peer review meetings were occurring monthly.

Outcome 8 – Data are collected correctly and reliably.

			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
26-27. The data collection system for target and replacement behaviors, was individualized, flexible, and extended to all treatment settings at San Antonio SSLC.

28. There were established measures of IOA, data collection timeliness, and treatment integrity.

29. There were not established frequency and minimal levels of IOA, data collection timeliness, and treatment integrity for any of the individual's PBSPs.

30. None of the individuals had data collection timeliness, and only Individual #130 had documentation of IOA in the last 6 months. Eight individuals (Individual #42 being the exception) had treatment integrity measures, however, goal frequencies of collection, and minimal acceptable levels, were not established.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.

			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	11% 2/18	0/2	0/2	0/2	1/2	0/2	1/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	11% 2/18	0/2	0/2	0/2	1/2	0/2	1/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/17	0/2	0/2	0/2	0/2	0/2	N/A	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #317 – gastrointestinal problems, and osteoporosis; Individual #253 – infections, and skin integrity; Individual #281 – aspiration, and osteoporosis; Individual #209 – cardiac disease, and weight; Individual #94 – falls, and seizures; Individual #54 – seizures, and urinary tract infections (UTIs); Individual #100 – osteoporosis, and seizures; Individual #87 – seizures, and other: hyperprolactinemia; and Individual #142 – seizures, and osteoporosis). From a medical perspective, the goals/objectives that were clinically relevant and achievable, and measurable were the ones for weight for Individual #209, and UTIs for Individual #54.

c. through e. Individual #54's goal was to be free of UTIs over the next year, and he had not had any since March 2014. For Individual #54's seizure risk and for the remaining individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of medical supports and services to these nine individuals.

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
g.	Individual receives timely preventative care:										
	i. Immunizations	44% 4/9	0/1	1/1	0/1	0/1	0/1	1/1	1/1	0/1	1/1
	ii. Colorectal cancer screening	75% 3/4	N/A	1/1	1/1	N/A	N/A	1/1	0/1	N/A	N/A
	iii. Breast cancer screening	100% 3/3	N/A	1/1	N/A	1/1	N/A	N/A	N/A	1/1	N/A
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	56% 5/9	0/1	1/1	0/1	0/1	1/1	0/1	1/1	1/1	1/1
	vii. Cervical cancer screening	100% 3/3	N/A	1/1	N/A	1/1	N/A	N/A	N/A	1/1	N/A
h.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	Not Rated									

Comments: g. The following provide some examples of problems noted:

- For Individual #317, an order was written on 9/23/15 for an L-S spine series noting that an order was written previously on 4/30/15. The Monitoring Team did not find this earlier order in the records, and it was not clear why five months lapsed before the order was re-written. The documentation of varicella was based on a history of childhood illness. There was no record of confirmation of immunity. The Centers for Disease Control (CDC) recommends special consideration be given to those who live in congregate settings. In its comments on the draft report, the State indicated: "A DEXA was attempted on 1/25/12 but not adequate due to too much movement. He was deemed by the IDT as a poor candidate for osteoporosis treatment so further DEXA scanning was discontinued as it is not likely to be as meaningful for treatment purposes…" However, this was inconsistent with what was found in Individual #317's records. The IDT may have documented that the individual was a poor candidate for osteoporosis treatment. However, In June 2015, the individual was started on Prolia for treatment of osteoporosis. The decision to start treatment with Prolia is not consistent with the comments that the individual is a poor candidate for osteoporosis treatment. Given that there is no baseline bone mineral density test. It is not clear what

the endpoint of therapy would be for this individual. The Vitamin D level remained markedly low at 17 on 8/25/15.

- For Individual #209, no DEXA scan was completed even though she had risk factors for osteoporosis and a marked vitamin D deficiency. In its comments on the draft report, the State indicated: "According to SASSLC and state guidelines this individual appears to not have specific risk factors for initial osteoporosis screening and is not currently considered a candidate for DEXA scanning, but rather monitoring as evidenced by the DADS Preventive Health Care Guidelines…" The QDRR documented several risks including sedentary lifestyle, uncorrected Vitamin D deficiency, and the use of long-term anti-epileptic drugs associated with osteoporosis. Additionally, the individual has received long-term treatment with proton pump inhibitors, which increases the risk for osteoporosis. She also had a persistent macrocytosis with 1+ macrocytosis that did not appear to have had an appropriate evaluation. Only one varicella dose was documented in 2009. In its comments, the State indicated that a titer on 6/5/15 revealed a positive result indicating immunologic response. The Facility did not submit or cite documentation to confirm this lab result, so the Monitoring Team's original finding stands.
- In the draft report, the Monitoring Team indicated that for Individual #54, a DEXA scan completed on 7/30/15 documented osteoporosis, but the PCP had not documented this finding in the AMA, dated 8/7/15. The Monitoring Team found no documentation of treatment other than Vitamin D and calcium. In its comments on the draft report, the State indicated: "DEXA on 7/6/11 demonstrated T score=-0.3 at the lumbar spine and -1.6 at the femur. Femur is consistent with early osteopenia. It appears that the DEXA is not due until July 2016, Individual #54 is in compliance as evidenced by the DADS Preventive Health Care Guidelines…" and "Individual #54 did not have a DEXA performed on 7/30/15. His last DEXA was in 2011 at which time he was diagnosed with osteopenia and prescribed bone maintenance supplements. He is not due for another DEXA until 2016 according to State and SASSLC guidelines. Another individual with the same last name as individual #54, had the DEXA on 7/30/15. The diagnosis of osteoporosis is documented in this individual's AMA and he is currently prescribed anti-osteoporosis medication every 6 months as treatment." Upon further review, in response to the Monitoring Team's document request #64, the Facility submitted incorrect information (i.e., a report for another individual). Notwithstanding the Facility's error of the document submission, Individual #54 had a DEXA in 2011 that was abnormal and showed osteopenia. He continued to have multiple risks including Vitamin D deficiency, long-term use of anti-epileptic drugs and proton pump inhibitors. The five-year interval for screening is appropriate for an individual with a normal bone mineral density who requires re-screening due to continued risks. The follow-up interval for individuals with abnormal studies is much shorter.
- Individual #100 had an incomplete colonoscopy that required repeating. Fecal occult blood testing was done, but this appeared to be done on campus and was not high-sensitivity fecal occult blood testing. The AMA stated he was below age 50, but he was actually 53 years old and required screening.
- In its comments on the draft report, the State indicated: "According to SASSLC and state guidelines this individual appears to not have specific risk factors for initial osteoporosis screening and is not currently considered a candidate for DEXA scanning, but rather monitoring as evidenced by the DADS Preventive Health Care Guidelines…" The IRRF documented multiple risks including sedentary lifestyle, long-term anti-epileptic drug use use, and a history of osteopenia in the right hip. The individual also had Vitamin D deficiency with the last documented level remaining sub-optimal at 24.
- With regard to varicella, CDC recommendations can be found at: http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf. The CDC guidelines note that vaccination should be emphasized for those who are at high risk of transmission, such as individuals living in institutions. Furthermore, evidence of immunity based on date of birth is limited to those born in the United States before 1980, excluding health care personnel and pregnant women. The "history of varicella must be based on diagnosis or verification of varicella

disease by a health care provider." A family member reporting a history of varicella is not adequate. Thus, for those without such documentation, evidence of immunity should include documentation of two does of varicella given at least four weeks apart or laboratory evidence of immunity.

h. This indicator was not rated during this review, but will be during upcoming reviews.

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.

			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	Individual with DNR that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: Individual #281 had had a DNR in place for 10 years "per family request." No clinical justification was found based on terminal illness or irreversible condition.

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.

			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	0% 0/12	N/A	0/1	N/A	0/2	0/2	0/1	0/2	0/2	0/2

b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	0% 0/12		0/1		0/2	0/2	0/1	0/2	0/2	0/2
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	100% 5/5		2/2	N/A	N/A	N/A	1/1	1/1	N/A	1/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	75% 3/4		2/2	N/A		N/A	1/1	0/1		N/A
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	83% 5/6		2/2	N/A		1/1	1/1	0/1		1/1
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 6/6		2/2	N/A		1/1	1/1	1/1		1/1
g.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 6/6		2/2	N/A		1/1	1/1	1/1		1/1
h.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 6/6		2/2	N/A		1/1	1/1	1/1		1/1
i.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	20% 1/5		1/2	N/A		0/1	0/1	0/1		N/A
j.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	43% 3/7		2/2	0/1		0/1	0/1	1/1		0/1

Comments: a. and b. For the individuals reviewed in relation to medical care, the Monitoring Team reviewed 12 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #253 (skin integrity on 9/18/15), Individual #209 (right elbow cellulitis on 6/15/15, and skin rash), Individual #94 (fall on 9/23/15, and fall on 9/29/15), Individual #54 (blepharitis on 5/26/15), Individual #100 (human bite on 6/16/15, and acute conjunctivitis on 7/16/15), Individual #87 (human bite on 6/9/15, and seizure on 8/24/15), and Individual #142 (facial trauma on 9/27/15, and status ulcer). Medical providers at San Antonio SSLC followed accepted clinical practice in assessing none of these acute illnesses.

The following provide a few examples of some of the problems noted with regard to the assessment and/or treatment of individuals at San Antonio SSLC:

- On 9/18/15, the PCP documented that Individual #253 had erythema to the buttocks area with no depth. The plan was to continue "complete skin care." The PCP never conducted any further assessment. The individual did not have resolution of this skin issue. The condition appeared to progress, as subsequent nursing documentation noted open areas continuing up until at least 10/13/15.
- On 9/23/15, the covering PCP documented in the IPN that Individual #94 fell straight onto his face from the standing position. Cervical spine x-rays were being checked. The PCP was notified by text and supportive care was being continued. There was never any documentation of the results of the x-rays. Similarly, on 9/29/15, another PCP entry noted that the individual fell while wearing a helmet and staff were concerned about nasal swelling. The individual had a history of a previous fracture. The exam was pertinent for a nasal laceration and swelling, and x-rays were ordered. There was never any follow-up documentation from a medical provider.
- On 6/15/15, another individual bit Individual #100 on the right forearm. Nursing noted an open wound of approximately one centimeter. The PCP was notified and prescribed Augmentin. The PCP saw the individual the next day and documented the status of the wound. However, there was no documentation related to the review of any potential to transmit infectious diseases. Specifically, the hepatitis status of both individuals should have been reviewed and documented. The PCP conducted no follow-up. On 6/24/15, the PCP documented a leukocytosis noting that it might have been related to the wound and would be re-checked.
- Individual #87 sustained a human bite to the left forearm. The individual was appropriately treated with Augmentin. Again, there was no documentation of infection control issues. Given the propensity of human bite wounds to become infected, appropriate monitoring for infection is important. The PCP did not document any follow-up assessments.
- Individual #142 had a stasis ulcer on the right foot, on which nursing staff maintained documentation over a period of four months. There was one PCP entry, dated 3/20/15, which indicated that the wound was healing and treatment would continue. The PCP did not document resolution or healing of the ulcer. For this individual, who had a number of medical problems including numerous falls, there were only two physician entries that reflected medical evaluations. Those were the assessments regarding the stasis ulcer and the post ED assessment (for 5/28/15).

c. The Monitoring Team reviewed seven acute illnesses requiring Infirmary admission, hospital admission, or ED visit, including the following with dates of occurrence: Individual #253 (pneumonia/cellulitis on 5/19/15, and cellulitis/aspiration pneumonia on 8/27/15), Individual #281 (Cholsytectomy on 4/6/15), Individual #94 (ED visit on 8/2/15), Individual #54 (nasal laceration on 5/20/15), Individual #100 (pneumonia on 7/28/15), and Individual #142 (laceration on 5/28/15). It was positive that, as applicable, prior to transfer, PCPs conducted assessments, or provided IPN summaries.

f. It was positive that for the individuals that were transferred to the hospital, the PCP or nurse communicated necessary clinical information with hospital staff.

g. For Individual #253, the IDT met to address the issues related to aspiration and concerns regarding the sudden deterioration in status. Aspiration risk was changed from medium to high, and a repeat Modified Barium Swallow Study was done.

h. The following are examples of good PCP follow-up:

- On 5/19/15, Individual #253 was transferred to the hospital with tachycardia and fever and was admitted with a right lower lobe pneumonia and cellulitis of the left foot. On 5/23/15, she retuned to the Facility. On 5/23/15 and 5/24/15, the PCP saw her. On 5/26/15, the PCP documented notification that there was erythema of the toe. There was notification on 5/29/15 of erythema and the antibiotic regimen was changed. On 6/11/15, the PCP documented that the foot was improving.
- On 8/27/15, Individual #253 was sent to the ED for evaluation of a facial rash and was admitted with a fungal rash. During that hospitalization, the individual also aspirated and acquired pneumonia. On 9/2/15, the individual returned to the Facility and a covering PCP saw her. Two hours later the individual was transferred back to the hospital due to a sudden deterioration with hypotension, fever, and lethargy. Upon return to the Facility on 9/5/15, the individual was seen by a third PCP who noted that the individual was admitted with hypoxia and hypotension. On 9/8/15, PCP noted that the cause of the hypotension was uncertain.

h. The following provide examples of problems noted:

- On 4/6/15, Individual #281 had abdominal surgery and on 4/9/15, was assessed at SASSLC. Post-operative assessments did not include information that would be typical, such as notation of the presence/absence of fever, nausea, vomiting, bowel movements, and pain assessment. There was no documentation of an abdominal examination. On 4/10/15, the PCP noted that erythema was noted at the drain. Vital signs were documented as "as noted."
- Individual #94 was diagnosed with a shoulder sprain. The PCP evaluated him upon return from the ED, but documented no follow-up assessments related to shoulder sprain or etiology of the fall that resulted in the injury.
- Individual #54 sustained a laceration to the nose associated with a seizure. He was referred to the ED for repair with Dermabond. On 5/21/15, he was seen with a plan to monitor for infection, but there was no follow-up by the PCP and no ISPA related to the seizures that caused the fall.
- On 7/27/15, Individual #100 was seen for an abnormal complete blood count with a white blood count of 14,000, which had been increasing. The PCP documented a normal exam, but noted the individual was unsteady on his feet and had wanted to stay in bed. The plan was to monitor for infection, but no diagnostics were ordered to rule out a sub-clinical infection. The individual began to refuse meals and demonstrated aggressive behavior, and on the morning of 7/28/15, was transferred to the ED. Per hospital records, a CT scan showed left lower lobe pneumonia. On 7/30/15, the individual returned to the Facility, and on 7/30/15 and 8/1/15, the PCP saw him. At the time of the review, the individual continued to have an increased white blood count up to 16,000, but had not had a formal hematology evaluation.
- On 5/28/15, Individual #142 sustained minor head trauma and was sent to the ED for repair of a laceration. Upon his return, the PCP saw him and documented that sutures would be removed in five days. The PCP conducted no further follow-up. Nursing staff documented difficulty removing the sutures and initially could only remove three sutures. It was not clear why the PCP did not intervene or assess the individual. The remaining three sutures were removed five days later by nursing staff.

Outcome 5 – Individuals' care and treatment is informed through non-Facility consultations.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	88% 15/17	1/2	2/2	2/2	2/2	1/1	2/2	2/2	2/2	1/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	76% 13/17	1/2	2/2	1/2	2/2	1/1	1/2	2/2	2/2	1/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	76% 13/17	2/2	2/2	2/2	0/2	0/1	2/2	2/2	2/2	1/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	82% 14/17	2/2	2/2	2/2	0/2	1/1	2/2	2/2	2/2	1/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/3	0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0/1

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 17 consultations. The consultations reviewed included those for Individual #317 for pulmonary on 8/19/15, and ophthalmology on 6/16/15; Individual #253 for pulmonary on 9/16/15, and neurology on 8/21/15; Individual #281 for neurology on 8/21/15, and gastroenterology (GI) on 5/28/15; Individual #209 for pulmonary on 7/17/15, and ophthalmology on 8/18/15; Individual #94 for neurology on 7/14/15; Individual #54 for urology on 6/2/15, and neurology of 8/4/15; Individual #100 for pulmonary on 9/16/15, and podiatry on 9/30/15; Individual #87 for neurology on 9/8/15, and MRI on 4/8/15; and Individual #142 for audiology on 7/2/15. The Facility failed to provide a second consultation for Individual #142, and instead provided a consultation for Individual #170, who was not in the group reviewed. All indicators were marked as "0," for the second consultation for Individual #142.

a. It was positive that for the individuals reviewed, PCPs generally reviewed and initialed consultation reports, and indicated agreement or disagreement with the recommendations. The exceptions were for Individual #317 for pulmonary on 8/19/15 (i.e., two PCPs reviewed two separate consults. The IPNs did not include the required information related to agreement or disagreement with the recommendations of the consultant. Furthermore, the consultations revolved around the issue of the need for a tracheotomy as a therapeutic intervention to decrease the incidence of aspiration. The IDT should have reviewed this consultation, but there was no documentation of an ISPA related to this matter), and Individual #142 for podiatry on 6/5/15 (i.e., for whom documentation was not available in the active record).

b. The reviews for which documentation was not present to show they were completed timely were those for Individual #317 for ophthalmology on 6/16/15, Individual #281 for gastroenterology (GI) on 5/28/15, Individual #54 for urology on 6/2/15, and Individual #142 for podiatry on 6/5/15. In some cases, weeks went by without consultation results from the external providers. As

clearly indicated in the audit tool guidelines, the Facility has an obligation to obtain the findings of the consultation within a reasonable time period. There should be a system in place to track consults. When they are not received in a timely manner, the Facility should request this information from the provider. A failure to do so, might delay implementation of treatment recommendations.

c. The consultations for which the PCP did not write a corresponding IPN that included the information that State Office policy requires were for Individual #209 for pulmonary on 7/17/15, and ophthalmology on 8/18/15; Individual #94 for neurology on 7/14/15; and Individual #142 for podiatry on 6/5/15.

d. When PCPs agreed with consultation recommendations, evidence was not submitted to show they were ordered for the following: Individual #209 for pulmonary on 7/17/15, and ophthalmology on 8/18/15; and Individual #142 for podiatry on 6/5/15.

e. For the following, evidence of IDT review was not found:

- Pulmonary recommended a tracheotomy for Individual #317, which was noted on a previous consult, dated 4/15/15. It was documented that this was the only additional support recommended to assist with the recurrent episodes of aspiration, but the individual's father did not support this intervention. Two PCPs reviewed two separate consults. Neither agreed nor disagreed and neither referred this to the IDT for review. The ISPAs reviewed did not discuss this recommendation.
- For Individual #87, the neurology consult documented that the MRI was negative. This interpretation actually was not correct. Per the PCP's IPN entry of the MRI report: "the images are near uninterpretable except for the diffusion. The anterior pituitary gland does appear slightly full on sagittal fast T1 images, but no definitive mass particularly without contrast and a cooperative individual. Impression of this MRI brain without contrast was limited with no acute abnormality. Mild fullness to the anterior pituitary without gross mass." The recommendation was to repeat the MRI with pre- and post-contrasts with sedation by anesthesia, if clinically appropriate. The PCP agreed with the recommendation, but this was not referred to the IDT and no repeat study was found. The individual had serum prolactin levels ranging from 140 t 170, which is significantly elevated.

Outcome 6 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	61% 11/18	0/2	0/2	2/2	2/2	1/2	2/2	2/2	0/2	2/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #317 – gastrointestinal problems, and osteoporosis; Individual #253 – infections, and skin integrity; Individual #281 – aspiration, and osteoporosis; Individual #209 – cardiac disease, and weight; Individual #94 – falls, and seizures; Individual #54 – seizures, and UTIs; Individual #100 – osteoporosis, and seizures; Individual #87 – seizures, and other: hyperprolactinemia; and Individual #142 – seizures, and osteoporosis).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed for the following individuals'

chronic diagnoses and/or at-risk conditions: Individual #281 – aspiration, and osteoporosis; Individual #209 – cardiac disease, and weight; Individual #94 – falls; Individual #54 – seizures, and urinary tract infections (UTIs); Individual #100 – osteoporosis, and seizures; and Individual #142 – seizures, and osteoporosis.

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.

			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	61% 11/18	1/2	0/2	2/2	2/2	1/2	2/2	2/2	0/2	1/2

Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, action steps assigned to the PCPs for the following individuals' risk areas were implemented: Individual #317 – gastrointestinal problems; Individual #281 – aspiration, and osteoporosis; Individual #209 – cardiac disease, and weight; Individual #94 – seizures; Individual #54 – seizures, and UTIs; Individual #100 – osteoporosis, and seizures; and Individual #142 – osteoporosis. The following provide examples of some of the concerns noted:

- For Individual #317, old x-rays suggested osteoporosis. This was not addressed in the AMA and no Quarterly Medical Summaries were completed. Based on this, a spinal series was recommended, since a DEXA could not be completed. On 9/23/15, an order was written for the individual to have an L-S spine series noting that an order was written previously on 4/30/15. The Monitoring Team did not find this previous order in the records, and it was not clear why five months lapsed before the order was re-written.
- Individual #253 was at risk for tuberculosis infection. The AMA simply stated "+PPD since 2012." There was no documentation that the appropriate assessment was completed. Per the CDC: "Should consider treatment for LTBI [latent tuberculosis infection] to prevent TB disease. The diagnosis of LTBI is based on information gathered from the medical history, TST [tuberculin skin test] or IGRA [Interferon-Gamma Release Assays] result, chest radiograph, physical examination, and in certain circumstances, sputum examinations. The presence of TB disease must be excluded before treatment for LTBI is initiated because failure to do so may result in inadequate treatment and development of drug resistance..." The Facility's management of this individual was not consistent with these guidelines.
- On a positive note, Individual #209 received treatment in a program that specialized in a medical condition that results in weight gain. The treatment resulted in some degree of success, but upon return to the Facility, the individual experienced a reversal in progress indicating that the supports are not effective. This might be due to a lack of clarity on how to properly implement the supports for a very complicated disorder.
- According to the IRRF, Individual #94 had 20 falls in 12 months, which was an increase in 10 falls from the previous year. In the past, most falls were attributed to seizures, however, seizure control had improved and falls did not appear seizure-related. The AMA did not include any discussion of the falls including those with injuries that occurred in the months just prior to the completion of the AMA. On 9/3/15, the PNMT MD noted VSS [vital signs stable], Neurology evaluation 7/15/15 - WNL [within normal limits], Assessment – fall; Discuss with Team, check Lamotrigine, F/u [follow-up] with PCP. However, there was no discussion of the numerous issues that might contribute to falls, such as gait, medications, orthostatic hypotension, cardiac

issues, vestibular problems, etc. On a related note, on 5/3/15, the individual slipped and fell in the shower and sustained a one-centimeter laceration to the left upper eyelid with swelling to the bridge of the nose, redness to the left temple and cheekbone. The pupils were reported to be sluggish, but there was no documented loss of consciousness. On 5/4/15, nursing noted the left eye was purplish with a small laceration, and on 5/6/15, bruising to the upper back was documented. There was never any documentation of physician notification of this event.

- Individual #87 had a history of status epilepticus in 2010. Seizure records appeared incomplete. For example, the eight-minute seizure documented in the IPN on 8/24/15 did not have a corresponding seizure record. On 9/8/15, the neurology consult did not reflect the history of the eight-minute seizure, nor did it accurately reflect the MRI report as documented by the PCP (i.e., "a very limited and poor study but fullness detected in the anterior pituitary which is the area of concern"). The PCP usually participated in this clinic evaluation and should have been aware of the eight-minute seizure and the need to repeat the MRI and that information should have been appropriately relayed to the consultant.
- Individual #87 had a prolactin level ranging from 149 to 170. Medications, particularly Risperidone, contribute to levels this high; however, microadenomas must be ruled out. The individual had an MRI that the radiologist documented was a limited study with images that were "near uninterpretable." However, the anterior pituitary appeared slightly full. The recommendation was to repeat with pre- and post-contrast with sedation by anesthesia, if clinically appropriate. The PCP agreed with the recommendation, but no follow-up study was ordered. The radiologist did not exclude the presence of a microadenoma. Additionally, the PCP did not address the prolactin level of 170, dated 9/17/14, in the December 2014 AMA. None of the IPNs documented whether or not the individual had any clinical manifestations of hyperprolactinemia.

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; any necessary additional laboratory testing is completed regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.

			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	N/A									

Comments: The Facility did not submit documentation to confirm that the Pharmacy completed new order review prior to dispensing medications.

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	78% 14/18	2/2	2/2	0/2	0/2	2/2	2/2	2/2	2/2	2/2
	ii. Benzodiazepine use;	67% 4/6	2/2	N/A	N/A	N/A	2/2	0/2	N/A	N/A	N/A
	iii. Medication polypharmacy;	78% 14/18	2/2	2/2	2/2	0/2	2/2	2/2	2/2	0/2	2/2
	iv. New generation antipsychotic use; and	100% 12/12	N/A	N/A	N/A	2/2	2/2	2/2	2/2	2/2	2/2
	v. Anticholinergic burden.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	94% 17/18	2/2	2/2	2/2	2/2	1/2	2/2	2/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	83% 10/12	N/A	N/A	N/A	2/2	2/2	1/2	2/2	1/2	2/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	90% 9/10	2/2	1/2	2/2	N/A	1/1	1/1	N/A	1/1	1/1

Comments: a. The Monitoring Team requested the last two QDRRs for nine individuals. It was positive that QDRRs had been completed quarterly.

b. Examples of problems identified included:

- The QDRRs for Individual #281 attributed anemia to anti-epileptic drugs without any mention of the characteristics of the anemia. No recommendation was included to repeat the vitamin D level, which was last obtained in December 2014 and was

24. No recommendation was included to obtain a bone mineral density in this individual with long-term anti-epileptic drug use, a sedentary lifestyle, and a vitamin D deficiency.

- The QDRRs for Individual #209 noted that the vitamin D level was low on current supplementation, but no recommendation was made. The individual's low red blood cell count was attributed to antipsychotics, but no comments were offered about the sustained macrocytosis. The QDRRs offered no comments about documented acidosis and the use of topiramate, which was also noted again on 10/13/15, with a serum bicarbonate of 19. With regard to polypharmacy, four medications were used as psychotropics, but the QDRRs offered no further discussion of their use and no other Facility-level review was cited.
- For Individual #54, the QDRRs included comments that no scheduled benzodiazepines were used. However, this individual utilized multiple doses of Ativan pro re nata (PRN) for seizure control and the QDRR did not document use of this medication as a stat/PRN or now medication.
- For Individual #87, the QDRRs included no discussion of psychotropic polypharmacy and no additional facility-level review was cited.

c. It was good to see that in many cases for the individuals reviewed, prescribers were reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations.

d. The PCP agreed to update the Active Problem List for Individual #253, but did not.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.

			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	N/A	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1

b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/7		0/1	0/1		0/1	0/1	0/1	0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/7		0/1	0/1		0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/7		0/1	0/1		0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/7		0/1	0/1		0/1	0/1	0/1	0/1	0/1

Comments: a. and b. The Monitoring Team reviewed seven individuals with medium or high dental risk ratings. Individuals did not have goals/objectives that provided the IDTs with clinically relevant information regarding individuals' progress. Most goals/objectives focused on a change or maintenance of oral hygiene ratings, which were only completed once or twice a year. Goals/objectives focusing on the causes of the medium or high risk dental rating and/or goals/objectives with more incremental measures would allow IDTs to determine whether or not the individual was progressing, regressing, or maintaining his/her status.

c. through e. Progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services to these seven individuals. For Individual #317 and Individual #209, who were at low risk for dental and who were in the outcome sample, the "deep review" items were not scored, but other items were scored.

Outcome 4 – Individuals maintain optimal oral hygiene.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs.	44% 4/9	1/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1	1/1

b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	44% 4/9	0/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	56% 5/9	0/1	0/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1
d.	If the individual has a fair or poor oral hygiene rating, individual receives at least two topical fluoride applications per year.	Not Rated									
e.	If the individual has need for restorative work, it is completed in a timely manner.	33% 1/3	N/A	N/A	0/1	N/A	0/1	1/1	N/A	N/A	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a., e., and f. Some examples of the problems with dental care included:

a. On 1/28/15, Individual #253 refused a dental exam. A note indicated an off-campus dentist would see her with TIVA. On 2/19/15, a note indicated she would be referred to an outside dentist. On 4/14/15, an outside dentist recommended a full mouth extraction, and noted that her oral hygiene was poor. However, according to the SASSLC dentist, a full-mouth extraction was not needed. The Facility did not submit the external consultation to document the opinion of the consulting dentist. Therefore, the Monitoring Team did not have access to the rationale for the consulting dentist's opinion. At the time of the onsite review, the individual remained without dental treatment.
b. On 1/26/15, Individual #94 was noted to be uncooperative, and the dentist completed a partial annual exam, and noted the need for multiple restorations with TIVA. The individual had moderate to severe periodontitis, 14 caries and two fractured teeth. The consent process was initiated. On 2/5/15, he had an unsuccessful prophylactic care visit. On 3/10/15, the Dental Clinic recorded another unsuccessful appointment, and noted that the appointment would be rescheduled with TIVA.
c. On 11/14/14, Individual #87 had an annual exam, but was uncooperative, and the assessment results were unknown. At the time of the review in November 2015, the Dental Department was waiting for the QIDP to return the TIVA consent.
d. For Individual #281, on 5/26/15, the concern for the pathology of tooth #3 was identified, but it was not yet addressed.

d. This indicator was not rated during this review, but will be during the next review.

Outcome 6 – Individuals receive timely, complete emergency dental care.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A									

b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A									
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									
Comments: Despite the fact that the Facility submitted a list indicating that Individual #253 had a dental emergency in the six months prior to the review (i.e., Document #TX-SA-1511-III.11.t), the records submitted for this individual did not include documentation of a dental emergency.											

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	0% 0/1	N/R	N/A	0/1	N/R	N/A	N/A	N/A	N/A	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/1			0/1						
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/1			0/1						
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/1			0/1						
Comments: Because Individual #317 and Individual #209 were a part of the outcome sample, and were at low risk for dental, some indicators were not rated for them (i.e., the "deeper review" indicators), including these related to suction tooth brushing. Individual #281's dentist recommended suction tooth brushing, and per the IRRF it is implemented. However, based on review of Document Request #70, it was not implemented, therefore no was data submitted.											

Outcome 8 – Individuals who need them have dentures.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	38% 3/8	N/A	0/1	1/1	1/1	0/1	0/1	0/1	0/1	1/1

b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: None.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	33% 4/12	N/A	2/2	N/A	0/2	1/2	0/2	1/2	N/A	0/2
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	33% 4/12		2/2		0/2	1/2	1/2	0/2		0/2
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	25% 2/8		1/1		0/2	0/2	0/1	1/1		0/1
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	33% 2/6		2/2		N/A	0/1	0/1	0/1		0/1
e.	The individual has an acute care plan that meets his/her needs.	0% 0/12		0/2		0/2	0/2	0/2	0/2		0/2
f.	The individual's acute care plan is implemented.	0% 0/12		0/2		0/2	0/2	0/2	0/2		0/2
Comments: The Monitoring Team reviewed 12 acute illnesses and/or acute occurrences for six individuals, including Individual #253 – UTI, pneumonitis, atelectasis, and cellulitis left foot on 5/19/15, and hospital acquired aspiration pneumonia, and fungal facial rash on 8/29/15; Individual #209 – rash on inner thighs and lower abdomen on 5/2/15, and cellulitis of the right elbow on 6/15/15; Individual #94 – soft tissue injury to right shoulder on 8/2/15, and fall with nose bleed on 9/28/15; Individual #54 – laceration to bridge of nose on 5/20/15, and acute blepharitis on 5/26/15; Individual #100 – human bite to right forearm on 6/15/15, and viral pneumonia on 7/28/15; and Individual #142 – laceration to right eyebrow and moderate head injury on 5/28/15, and fall with mild soft tissue swelling on 6/27/15.											

a. The acute illnesses/occurrences for which nursing assessments were performed included Individual #253 – UTI, pneumonitis, atelectasis, and cellulitis left foot on 5/19/15, and hospital acquired aspiration pneumonia, and fungal facial rash on 8/29/15; Individual #94 – fall with nose bleed on 9/28/15; and Individual #100 – human bite to right forearm on 6/15/15. Upon initial onset of acute illnesses/occurrences, some examples of missing nursing assessments for individuals with acute illnesses were missing vital signs, or missing neurological checks, as applicable to the individual's needs.

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms and communicated assessment information per the relevant nursing protocol were: Individual #253 – UTI, pneumonitis, atelectasis, and cellulitis left foot on 5/19/15, and hospital acquired aspiration pneumonia, and fungal facial rash on 8/29/15; Individual #94 – fall with nose bleed on 9/28/15; and Individual #54 – laceration to bridge of nose on 5/20/15.

c. The acute illnesses/occurrences treated at the Facility for which licensed nursing staff conducted ongoing assessments were those for Individual #253 – hospital acquired aspiration pneumonia, and fungal facial rash on 8/29/15; and Individual #100 – human bite to right forearm on 6/15/15. For the remaining acute illnesses/occurrences, there was no follow-up, the frequency of the follow-up was not consistent with nursing protocols or other current standards of practice, and/or incomplete nursing assessments were completed.

d. Nursing staff conducted pre- and post-hospitalization assessments for Individual #253 – UTI, pneumonitis, atelectasis, and cellulitis left foot on 5/19/15, and hospital acquired aspiration pneumonia, and fungal facial rash on 8/29/15.

e. In some cases, an acute care plan should have been developed, but was not. Based on comments the State provided in response to the draft report, there appears to be a serious misunderstanding of when acute care plans are needed. For example, the State indicated: "…If an IHCP is in place than (sic) an ACP would not be required… Additionally there are some ailments that would be followed with corresponding protocol rather than with an ACP." As the Monitor has previously discussed with State Office, this position is not consistent with current standards of practice. For those that were developed, the plans did not include instructions regarding follow-up nursing assessments, or identify the frequency with which monitoring should occur. In addition, they were not in alignment with nursing protocols; did not include specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; and did not define the clinical indicators nursing would measure.

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.

			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	39% 7/18	0/2	1/2	0/2	0/2	2/2	2/2	0/2	1/2	1/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #317 – respiratory compromise, and constipation/bowel obstruction; Individual #253 – skin integrity, and infections; Individual #281 – constipation/bowel obstruction, and gastrointestinal problems; Individual #209 – skin integrity, and infections; Individual #94 – seizures, and falls; Individual #54 – urinary tract infections (UTIs), and seizures; Individual #100 – infections, and skin integrity; Individual #87 – seizures, and falls; and Individual #142 – skin integrity, and falls). None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #253 – infections; Individual #94 – seizures, and falls; Individual #54 – UTIs, and seizures; Individual #87 – falls; and Individual #142 – falls.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provision of nursing supports and services to these nine individuals.

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.

			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/8	0/1	0/2	N/A	N/A	0/1	N/A	0/2	N/A	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	7% 1/15	0/2	0/2	0/2	N/A	0/1	1/2	0/2	0/2	0/2

Comments: As noted above, the Monitoring Team reviewed a total of 18 IHCPs for nine individuals addressing specific risk areas.

a. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner.

b. Individuals for whom their at-risk conditions required immediate action, but documentation did not show IDTs took necessary action were Individual #317 – constipation/bowel obstruction; Individual #253 – skin integrity, and infections; Individual #94 – falls; Individual #100 – infections, and skin integrity; and Individual #142 – falls, and skin integrity.

c. Generally, for the individuals reviewed, documentation was not available to show the nursing interventions included in IHCPs were implemented thoroughly. The exception was for Individual 354 - seizures. For Individual #209 – skin integrity, and infections, and Individual #94 – seizures, despite these individuals having high or medium risk in these areas, IHCPs included no nursing interventions.

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	Individual receives prescribed medications in accordance with applicable standards of care.	83% 19/23	2/2	2/2	2/2	1/1	1/2	2/2	1/2	1/2	1/2

b.	Medications that are not administered or the individual does not accept are explained.	50% 4/8	N/A	1/1	1/1	1/1	0/1	1/1	0/1	0/1	0/1
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 14/14	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	33% 3/9	0/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1
e.	Individual's PNMP plan is followed during medication administration.	92% 12/13	1/1	1/1	N/A	N/A	1/1	1/1	1/1	1/1	1/1
f.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	93% 13/14	0/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	25% 2/8	0/1	0/1	N/A	0/1	0/1	0/1	1/1	0/1	1/1
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	44% 4/9	0/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	13% 1/8	N/A	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

		Individuals:									
#	Indicator		186	194	4	68	178	299			
	Individual receives prescribed medications in accordance with applicable standards of care.		1/1	1/1	1/1	1/1	1/1	1/1			
	Medications that are not administered or the individual does not accept are explained.		N/A	N/A	N/A	N/A	N/A	N/A			
	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).		1/1	1/1	1/1	1/1	1/1	1/1			
	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.		N/A	N/A	N/A	N/A	N/A	N/A			
	Individual's PNMP plan is followed during medication administration.		1/1	1/1	1/1	0/1	1/1	1/1			
	Infection Control Practices are followed before, during, and after the administration of the individual's medications.		1/1	1/1	1/1	1/1	1/1	1/1			
	Instructions are provided to the individual and staff regarding new orders or when orders change.		N/A	N/A	N/A	N/A	N/A	N/A			
	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.										
	If an ADR occurs, the individual's reactions are reported in the IPNs.										
	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.										
	If the individual is subject to a medication variance, there is proper reporting of the variance.										
	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.										

Comments: The Monitoring Team conducted record reviews for nine individuals (i.e., Individual #317, Individual #253, Individual #281, Individual #209, Individual #94, Individual #54, Individual #100, Individual #87, and Individual #142) and observations of medication administration for 14 individuals (i.e., Individual #317, Individual #253, Individual #281, Individual #94, Individual #54, Individual #100, Individual #87, Individual #142, Individual #186, Individual #194, Individual #4, Individual #68, Individual #178, and Individual #299).

a. and b. Problems noted included medications being "out of stock," circled Medication Administration Record (MAR) blanks without explanation for why the medication was not administered, and unexplained MAR blanks.

c. It was positive to see that for the individuals the Monitoring Team member observed during medication passes, nursing staff followed the nine rights of medication administration.

d. Nursing staff administered PRN medication, but at times, did not document the reason, route, and/or the individual's reaction or the effectiveness of the medication.

e. and f. It was positive that with few exceptions for the individuals with PNMPs that the Monitoring Team observed, nursing staff followed the PNMPs as well as infection control practices during the observations.

k. Staff had not completed medication variance forms for a number of variances, and, at times, forms that were completed had never been finalized.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/16	0/1	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	56% 9/16	0/1	0/2	2/2	1/2	1/1	1/2	1/2	1/2	2/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/16	0/1	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/16	0/1	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/16	0/1	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2

b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	33% 2/6	1/1	1/1	N/A	N/A	0/1	0/1	0/1	N/A	0/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/1	0/1			0/1	0/1	0/1		0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/6	0/1	0/1			0/1	0/1	0/1		0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6	0/1	0/1			0/1	0/1	0/1		0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/6	0/1	0/1			0/1	0/1	0/1		0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/1	0/1			0/1	0/1	0/1		0/1

Comments: The Monitoring Team reviewed 16 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration for Individual #317; aspiration, and skin integrity for Individual #253; aspiration, and falls for Individual #281; falls, and choking for Individual #209; choking for Individual #94; choking, and falls for Individual #54; aspiration, and falls for Individual #100; falls, and choking for Individual #87; and falls, and fractures for Individual #142.

a.i. and a.ii. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: aspiration, and falls for Individual #281; falls for Individual #209; choking for Individual #94; falls for Individual #54; falls for Individual #100; falls for Individual #87; and falls, and fractures for Individual #142.

b.i. The Monitoring Team reviewed six areas of need for six individuals that met criteria for PNMT involvement, including: respiratory compromise for Individual #317, other: swallowing issues for Individual #253, falls for Individual #94, choking for Individual #54, falls for Individual #100, and falls for Individual #142. Individual #317 and Individual #253 were appropriately referred to the PNMT. Individual #94 was not referred to the PNMT timely (i.e., not until 9/4/15) despite 30 falls in the previous six months. On 6/29/15, Individual #54 reportedly choked on eggs, but there was no evidence the PNMT conducted a review related to the incident on this date (i.e., there was review of another choking event on 12/5/14). For Individual #100, there was no evidence of full PNMT review at the threshold of six falls within 60 days (i.e., he had at least 10 documented falls between 4/5/15 and 7/15/15). Individual #142 had six falls recorded from 4/5/15 to 5/17/15, and again from 5/8/15 to 7/15/15, and his falls continued. At the ISP Preparation meeting the Monitoring Team attended during the week of the onsite review, IDT members reported that he had experienced another six falls in the last month and there was still no referral to the PNMT.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT had not developed clinically relevant and achievable goals/objectives for these individuals.

a.iii. through a.v, and b.iv. through b.vi. As noted above, some individuals were not referred to the PNMT when they should have been, and, therefore, did not have necessary goals/objectives. As a result, these indicators were scored "0." Overall, in addition to a lack of measurable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result of the lack of data, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure clinically relevant outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.

			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	20% 2/10	0/2	1/2	N/A	N/A	0/2	1/1	0/2	N/A	0/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/2	0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A

Comments: a. As noted above, most IHCPs did not include all of the necessary PNM action steps to meet individuals' needs. In addition, the timeframes and/or criteria for the completion of actions steps were often vague, and, as a result, there was no way to measure their completion.

b. The following provide some examples of IDTs' responses to changes in individuals' PNM status:

- Individual #253's IDT referred her immediately to the PNMT when a hospital diagnosed her as having aspiration pneumonia, which was good. As discussed elsewhere, because the PNMT did not generate a comprehensive assessment, a full set of recommendations was not made available to the IDT.
- On 8/3/15, Individual #94 reportedly had a near choking event. No evidence was found to show the IDT held an ISPA meeting related to this incident. The SLP and OT completed mealtime observations through 8/5/15, and reported that they did not observe any issues. Apparently a family member brought in tacos, which were not of the correct safe food texture and staff did not identify this as a problem or correct the food texture. At a minimum, the IDT should have taken steps to prevent a recurrence.

- Individual #94 also had a history of falls at least since May 29, 2015, and a history of injuries in previous years, including a nasal fracture, but no evidence was found of IDT discussion related to the need to refer him to the PNMT. Also no evidence was found of IDT therapists reviewing the frequency and circumstances around his falls (i.e., there was only one PNMT PT note on 9/1/15). The PNMT had been reviewing him in a limited manner (i.e., little documentation). The PNMT meeting minutes documented that they would request a referral from the IDT.
- Based on the IPNs for Individual #100, no evidence was found that the IDT made a referral to the PNMT related to his falls, nor was there evidence of involvement by IDT PT. IDT therapists also did not appear to follow-up post-hospitalization or after falls with injury as far back as March 2015.
- For Individual #142, no evidence was found of ISPA meetings related to his frequent falls. In its response to the draft report, the State questioned this finding and indicated that: "Based on the IPNs provided through Document Request Item TX-SA-1511-II.13…, page 2, an ISPA meeting was held on 09/29/2015 to discuss falls for Individual #142." As noted above, Individual #142 had six falls recorded from 4/5/15 to 5/17/15, and again from 5/8/15 to 7/15/15, and his falls continued. No ISPA meetings were held in response to the falls that occurred from April to July. Moreover, the documentation the State referenced in its comments was an IPN, not ISPA documentation. The brief note was from a nurse, and did not represent a signed, addendum to his ISP. If an ISPA meeting did occur on 9/29/15, it was very overdue, and failed to meet Individual #142's need for urgent attention beginning back at least as early as April 2015.

c. For Individual #317, a discharge meeting was held, but recommendations as outlined in the PNMT assessment were not clearly documented as implemented/completed and no plan was instituted to ensure this. Individual #100 was discharged from the PNMT on 10/1/15, but no ISPA documented the plan moving forward.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	53% 31/58
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	50% 0/2
Comments: a. The Monitoring Team conducted 58 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 13 out of 22 observations (59%). Staff followed individuals' dining plans during 12 out of 25 mealtime observations (48%). Transfers were completed according to the PNMPs in six of 11 observations (55%).		

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	0% 0/1	N/A		0/1						
Comments: As noted above, for Individual #281, the IDT discussed the potential to begin bolus feedings, but did not develop a plan to address it.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	25% 2/8	N/A	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	25% 2/8		0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/8		0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/8		0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/8		0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. The ISPs that included clinically relevant and achievable goals/objectives to address individuals' OT/PT needs were those for Individual #281, and Individual #94. For some individuals, OT/PT assessments included specific goals/objective related to skilled therapy and/or the ISP narrative indicated IDTs had agreed upon OT/PT goals/objectives, but the IDTs did not include them in action plans (e.g., Individual #253, Individual #87, and Individual #54). In other instances, individuals that clearly needed OT/PT related goals did not have them (e.g., Individual #100, who experienced 12 falls from 2/1/15 to 5/15/15, or Individual #209, for whom assessments did not discuss the need for an exercise program despite obese status and a diagnosis of Prader Willi). Based on comments the State submitted in response to the draft report, Facility staff should carefully review the audit tools, including the interpretive											

guidelines. Goals/objectives require IDT review and approval, and must be included in the ISP or incorporated into the ISP through an ISPA.

c. through e Based on a review of Individual #317 assessment, he did not require formal OT/PT services and supports. Because he was part of the outcome group, no further review was conducted. For the remaining eight individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of integrated ISP progress reports showing the individuals' progress on their goals/objectives.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.

			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	60% 3/5	N/R	0/1	1/1	N/A	1/1	1/1	N/A	0/1	N/A
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/2		0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A

Comments: a. and b. Problems noted include:

- For Individual #253, no evidence was provided that head to midline direct therapy was provided, and there was no evidence the IDT decided to terminate the therapy.
- For Individual #87, no evidence was found that the direct therapy for elbow range of motion was implemented, and there was no evidence the IDT decided to terminate the therapy. In its comments on the draft report, the State indicated that: "Therapy for elbow range of motion was initiated on 12/10/2014 and terminated on 12/18/2014, one day after the 12/17/2014 ISPA…" Based on the Monitoring Team's review of documentation submitted, there does not appear to be evidence that the IDT held an ISPA to initiate therapy. The evaluation was completed on 12/3/14. The State indicated it was initiated on 12/10/14. However, the ISP on 12/17/14 (i.e., not an ISPA on 12/17/14 as the State indicated) presented the evaluation information with a recommendation for intervention. The ISP did not indicate that treatment had been provided with plan to terminate the next day.
- For Individual #54, data was presented to show implementation of direct PT from 8/24/15 to 9/23/15. However, although it did not appear that he met criteria, it was unclear whether or not the service was terminated. No further data was submitted, but no ISPA meeting documentation was submitted to show that the IDT agreed to end the PT services.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
			Individuals:								
#	Indicator	Overall Score	335	31	287	228	149	106	92	258	248
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	100% 23/23	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	96% 25/26	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	85% 22/26	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		32	151	30	306	79	328	23	281	239
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/2	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/2	0/1	2/2	0/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		347	47	154	274	101	54			
	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1			
	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	1/1	1/1			
	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	1/1			

Comments: a. The Monitoring Team conducted observations of 26 pieces of adaptive equipment. The individuals the Monitoring Team observed had clean adaptive equipment, which was good to see. For three individuals, the adaptive equipment was under their clothing, so this indicator could not be rated.

b. The elbow pads for Individual #32 were around his wrists instead of on his elbows.

c. Issues with proper fit were noted for four individuals. Based on observation of Individual #228 and Individual #306 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Facility's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors. In addition, the elbow pads for Individual #32 and Individual #151 were broken down.

Domain #4: Individuals in the Target Population will engage in meaningful activities, through participation in active treatment, community activities, work and/or educational opportunities, and social relationships consistent with their individual support plan.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.

			Individuals:								
#	Indicator	Overall Score	94	346	142	342	253	209			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
Once San Antonio SSLC develops individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals and, thus, the facility can achieve compliance with this outcome and its indicators.

4-7. Overall, personal goals were undefined. Therefore, there was no basis for assessing progress in these areas. Revisions to supports did not generally occur when individuals were not making progress (or if plans were not implemented). There was no documentation to show that the IDT met to discuss their lack of progress or revised the ISP to address any barriers to achieving outcomes.

See Outcome 7, Indicator 37, for additional information regarding progress, regression, and appropriate IDT actions for ISP action plans.

Outcome 8 – ISPs are implemented correctly and as often as required.

			Individuals:								
#	Indicator	Overall Score	94	346	142	342	253	209			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0%	0/1	0/1	0/1	0/1	0/1	0/1			

		0/6									

Comments:
39-40. A review of data sheets, QIDP monthly reviews, and observations while onsite did not support that action plans were being consistently implemented.

- For Individual #142, SAP data sheets showed no data for August 2015 and September 2015 for brushing his teeth and counting money and only two trials for each in July 2015. His QIDP monthly reviews indicated that from April 2015 through June 2015, data were not available for his nine action plans and for July 2015 through September 2015, data were only available for one of nine action plans.
- For Individual #94, no data were recorded for his living option and relationship action plans from April 2015 through September 2015. No data were recorded for his greater independence and recreation/leisure action plans from April 2015 through July 2015 and data showed inconsistent implementation of his work goal.
- Data were not available to support consistent implementation of Individual #346 or Individual #209's action plans.
- Individual #342's QIDP monthly reviews indicated that his action plans were not implemented from April 2015 through August 2015.
- For Individual #253, her QIDP monthly reviews indicated that her living option, relationship, and recreation/leisure action plans were not implemented from April 2015 through August 2015.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.

			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
6	The individual is progressing on his/her SAPS	50% 11/22	2/3	1/1	1/3	1/3	0/3	1/1	0/3	2/2	3/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/3	N/A	N/A	N/A	N/A	N/A	0/1	N/A	0/1	0/1
8	If the individual was not making progress, actions were taken.	0% 0/11	0/1	N/A	0/2	0/2	0/3	N/A	0/3	N/A	N/A
9	Decisions to continue, discontinue, or modify SAPs were data based.	36% 8/22	2/3	1/1	1/3	1/3	0/3	0/1	0/3	1/2	2/3

Comments:
6. Because good reliable data were not available, a determination of progress could not be made for the SAPs. The exceptions were the SAPs for Individual #94 and Individual #142 that were observed by the Monitoring Team to be implemented and scored correctly. That being said, the facility's reports showed that 11 of the 22 SAPs (including both of those) were met or progressing. The Monitoring Team was unable to assess if progress was being made on the other four SAPs (i.e., Individual #142's brush teeth and make a purchase SAPs, Individual #342's work 15 minutes SAP, and Individual #42's save money SAP) because at least three months of data were not available

to review.

7-9. Three SAP objectives were reported by the facility to be achieved (i.e., Individual #142's complete work SAP, Individual #342's trail the wall SAP, and Individual #39's work on task SAP), however, all were continued without introducing a new objective. Similarly, in none of the 11 SAPs that were judged as not progressing (e.g., Individual #130's wash clothes SAP), was there evidence that actions were taken to address the lack of progress (e.g., retrain staff, modify the SAP, discontinue the SAP). Overall, there appeared to be data based decisions to continue, discontinue, or modify SAPs in 36% of the SAPs.

Outcome 4- All individuals have SAPs that contain the required components.

			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
13	The individual's SAPs are complete.	19% 5/26	0/3	0/2	0/3	2/3	2/3	1/3	0/3	0/3	0/3

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Although only five SAPs (i.e., Individual #346's make purchases and wash clothes SAPs, Individual #130's make purchases and wash clothes SAPs, and Individual #142's brush teeth SAP) were found to be complete, the majority of the other SAP components were found in most SAPs. The most common missing component was the use of a task analysis. Many of the SAPs just contained one step (e.g., Individual #94's toothbrushing SAP) suggesting that these either should be broken down into more steps to be most effective (e.g., Individual #94's open the milk carton SAP), or really represented compliance issues rather than the acquisition of new skills (e.g., Individual #346's conduct himself in a socially appropriate way in the community SAP). Additionally, several SAPs had multiple steps, but because the instructions indicated that that the training methodology was whole task, they were functionally one step. For example, Individual #142's complete work tasks SAP had two steps, complete 5 units of a task and complete 10 units of a task. The training methodology was total task, so the SAP really was one step: complete 10 units of a task. The task analysis in other SAPs (e.g., Individual #142's make a purchase SAP), combined the necessary behaviors to complete the task and the level of prompts. Another common component missing was specific instructions concerning the methodology used to teach the skill. For example, Individual #154's purchase an item SAP did not indicate the training methodology, so it was unclear if all the steps were to be trained or just one at a time.

Outcome 5- SAPs are implemented with integrity.

			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
14	SAPs are implemented as written.	50% 2/4	1/1	N/A	N/A	0/1	N/A	1/1	N/A	N/A	0/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and	0% 0/26	0/3	0/2	0/3	0/3	0/3	0/3	0/3	0/3	0/3

	achieved.										

Comments:
14. The Monitoring Team observed the implementation of four SAPs. Two were judged to be implemented with integrity (Individual #142's complete work SAP, Individual #94's brushing his teeth SAP). The other two SAPs observed by the Monitoring Team were not implemented with integrity. The DSP implementing Individual #39's work on task SAP recorded the SAP data incorrectly, while the DSP implementing Individual #346's toothbrushing SAP did not utilize the correct level of prompts.

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. San Antonio SSLC recently began to conduct SAP integrity checks. They developed a schedule of two SAP integrity assessments per week per residence and work site. It is suggested that the facility establish a frequency goal of checking the integrity of each SAP at least once every six months, and establish a minimum level of acceptable integrity scores (e.g., 80%).

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
16	There is evidence that SAPs are reviewed monthly.	15% 4/26	3/3	0/2	1/3	0/3	0/3	0/3	0/3	0/3	0/3
17	SAP outcomes are graphed.	42% 11/26	3/3	2/2	1/3	3/3	1/3	1/3	0/3	0/3	0/3

Comments:
16. The majority of SAP outcomes were reviewed in the QIDP monthly reviews. Some, however, did not include SAP data (e.g., Individual #130's make purchases SAP), and others (e.g., Individual #342's signing SAP) were reviewed in QIDP meetings that were labeled as monthly meetings, but were all dated on the same date in August 2015 or September 2015. These appeared to be more of a multiple-month progress note than a monthly review and, therefore, they were not rated as monthly meetings.

17. The majority of the SAPs did not have data consistently graphed (e.g., Individual #154's purchase item SAP).

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
18	The individual is meaningfully engaged in residential and treatment sites.	33% 3/9	2/7	4/5	2/6	4/5	1/3	4/4	1/5	2/5	2/3
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	level scores.	9/9									
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: 18-21. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found three (Individual #142, Individual #346, Individual #42) of the nine individuals (33%) consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations). San Antonio SSLC conducted monthly engagement measures in all residential and day programming sites. Their established goal was individualized to each residence and day program site. The facility's engagement data indicated that none of the residential and day treatment sites of the individuals achieved their goal level of engagement.											

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
			Individuals:								
#	Indicator	Overall Score	94	42	154	346	130	142	264	342	39
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	17% 1/6	0/1	N/A	0/1	1/1	0/1	0/1	N/A	N/A	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: 22-23. It was encouraging to see that San Antonio SSLC established individualized goals for the frequency of residence community outings and SAP training in the community. Individual #42, Individual #264 and Individual #342 did not have a goal for SAP training in the community. None of the individuals, however, achieved their community outings goal, and only Individual #346 achieved his SAP training in the community goal.											

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
			Individuals:								
#	Indicator	Overall Score	346								
25	The student receives educational services that are integrated with the ISP.	100% 1/1	1/1								
Comments: 25. Individual #346 was the only individual reviewed that was under 22 years of age. He graduated from school in June 2015, where he											

was receiving services from the local independent school. Additionally, the IDT worked with the school district to provide appropriate educational services. Individual #346's most recent ISP was after he graduated from school, so his IEP and school related action plans were not in his ISP.

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: These indicators were not applicable to any of the individuals the Monitoring Team responsible for reviewing physical health reviewed.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	83% 5/6	1/1	1/1	1/1	N/A	0/1	1/1	N/A	1/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	83% 5/6	1/1	1/1	1/1		0/1	1/1		1/1	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/6	0/1	0/1	0/1		0/1	0/1		0/1	

d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/6	0/1	0/1	0/1		0/1	0/1		0/1	
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/6	0/1	0/1	0/1		0/1	0/1		0/1	

Comments: a. and b. The ISPs that included clinically relevant, achievable, and measurable goals/objectives to address individuals' communication needs were those for Individual #317, Individual #253, Individual #281, Individual #54, and Individual #87.

c. through e. Based on a review of Individual #209's assessment, she did not require formal communication services and supports. Because she was part of the outcome group, no further review was conducted. Based on a review of Individual #100 and Individual #142's assessments, they did not require formal communication services and supports, but because they were part of the core group, full reviews were conducted. For the remaining six individuals, the Monitoring Team completed full reviews due to a lack of integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.

			Individuals:								
#	Indicator	Overall Score	317	253	281	209	94	54	100	87	142
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	40% 2/5	0/1	1/1	1/1	NR	N/A	0/1	N/A	0/1	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	100% 1/1	N/A	N/A	N/A		N/A	1/1	N/A	N/A	N/A

Comments: b. With regard to termination of services and supports:

- For Individual #54, the IDT discontinued the communication plan, because strategies were to be included in the PNMP, ISP, PBSP and other SAPs.

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.

			Individuals:								
#	Indicator	Overall Score	165	234	7	328	79	248	88	50	333
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	82% 9/11	N/A	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1

b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	55% 6/11	1/1	0/1	0/1	0/1	0/1	N/A	1/1	0/1	1/1
			Individuals:								
#	Indicator		335	171							
•	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		2/2	1/1							
•	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		2/2	1/1							
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	50% 4/8									
Comments: None.											

Domain #5: Individuals in the Target Population who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and will transition to the most integrated setting(s) necessary to meet their appropriately identified needs, consistent with their informed choice.

Outcomes, indicators, and scores for this Domain will be included in the next Monitoring Team Report.

APPENDIX A – Interviews and Documents Reviewed

Interviews: Interviews were conducted of individuals, direct support professionals, nursing, medical, and therapy staff.

Documents:

- List of all individuals by residence, including date of birth, date of most recent ISP, date of prior ISP, date current ISP was filed, name of PCP, and the name of the QIDP;
- In alphabetical order: All individuals and their at-risk ratings (i.e., high, medium, or low across all risk categories), preferably, this should be a spreadsheet with individuals listed on the left, with the various risk categories running across the top, and an indication of the individual's risk rating for each category;
- All individuals who were admitted since the last review, with date of admission;
- Individuals transitioned to the community since the last review;
- Community referral list, as of most current date available;
- List of individuals who have died since the last review, including date of death, age at death, and cause(s) of death;
- List of individuals with an ISP meeting, or a ISP Preparation meeting, during the onsite week, including name and date/time and place of meeting;
- Schedule of meals by residence;
- For last year, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit);
- For last year, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay);
- Lists of:
    - All individuals assessed/reviewed by the PNMT to date;
    - Current individuals on caseload of the PNMT, including the referral date and the reason for the referral to the PNMT;
    - Individuals referred to the PNMT in the past six months;
    - Individuals discharged by the PNMT in the past six months;
    - Individuals who receive nutrition through non-oral methods. For individuals who require enteral feeding, please identify each individual by name, living unit, type of feeding tube (e.g., G-tube, J-tube), feeding schedule (e.g., continuous, bolus, intermittent, etc.), the date that the tube was placed, and if the individual is receiving pleasure foods and/or a therapeutic feeding program;
    - Individuals who received a feeding tube in the past six months and the date of the tube placement;
    - Individuals who are at risk of receiving a feeding tube;
    - In the past six months, individuals who have had a choking incident requiring abdominal thrust, date of occurrence, and what they choked on;
    - In the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions;
    - In the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status;
    - In the past six months, individuals who have experienced a fracture;
    - In the past six months, individuals who have had a fecal impaction or bowel obstruction;
    - Individuals' oral hygiene ratings;
    - Individuals receiving direct OT, PT, and/or speech services and focus of intervention;
    - Individuals with Alternative and Augmentative Communication (ACC) devices (high and low tech) and/or environmental control device related to communication, including the individual's name, living unit, type of device, and date device received;
    - Individuals with PBSPs and replacement behaviors related to communication;

    - Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
    - In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
    - In the past six months, individuals with dental emergencies;
    - Individuals with Do Not Resuscitate Orders, including qualifying condition; and
    - In the past six months, individuals with adverse drug reactions, including date of discovery.
- Lists of:
    - Crisis intervention restraints.
    - Medical restraints.
    - Protective devices.
    - Any injuries to individuals that occurred during restraint.
    - DFPS cases.
    - All serious injuries.
    - All injuries from individual-to-individual aggression.
    - All serious incidents other than ANE and serious injuries.
    - Non-serious Injury Investigations (NSIs).
    - Lists of individuals who:
        - Have a PBSP
        - Have a crisis intervention plan
        - Have had more than three restraints in a rolling 30 days
        - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
        - Were reviewed by external peer review
        - Were reviewed by internal peer review
        - Were under age 22
    - Individuals who receive psychiatry services and their medications, diagnoses, etc.

- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- For last year, in alphabetical order by individual, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit)
- For last year, in alphabetical order by individual, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay)
- Facility policies related to:
    a. PNMT
    b. OT/PT and Speech

c. Medical
d. Nursing
e. Pharmacy
f. Dental

- List of Medication times by home
- All DUE reports completed over the last six months (include background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results)
- For all deaths occurring since the last review, the recommendations from the administrative death review, and evidence of closure for each recommendation (please match the evidence with each recommendation)
- Last two quarterly trend reports regarding allegations, incidents, and injuries.
- QAQI Council (or any committee that serves the equivalent function) minutes (and relevant attachments if any, such as the QA report) for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.
- The facility's own analysis of the set of restraint-related graphs prepared by state office for the Monitoring Team.
- The DADS report that lists staff (in alphabetical order please) and dates of completion of criminal background checks.
- A list of the injury audits conducted in the last 12 months.
- Polypharmacy committee meeting minutes for last six months.
- Facility's lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.
- Facility's most recent obstacles report.
- A list of any individuals for whom you've eliminated the use of restraint over the past nine months.
- A copy of the Facility's guidelines for assessing engagement (include any forms used); and also include engagement scores for the past six months.
- Calendar-schedule of meetings that will occur during the week onsite.

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP, including dining plans, positioning plans, etc. with all supporting photographs used for staff implementation of the PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- QIDP monthly reviews/reports, and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request
- QDRRs: last two, including the Medication Profile
- Any ISPAs related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months

- IPNs for last six months, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- ED transfer sheets, if any
- Any ED reports (i.e., not just the patient instruction sheet)
- Any hospitalization reports
- Immunization Record from the active record
- AVATAR Immunization Record
- Consents for immunizations
- Medication Variance forms and follow-up documentation for the last six months (i.e., include the form and Avatar Report)
- Annual Nursing Assessment, and associated documents (e.g., Braden Scale, weight record)
- Last two quarterly nursing assessments, and associated documents (e.g., Braden Scale, weight record)
- Acute care plans for the last six months
- Direct Support Professional Instruction Sheets, and documentation validating direct support professionals training on care plans, including IHCPs, and acute care plans
- Last three months Eternal Nutrition Flow Record, if applicable
- Last three months Aspiration Trigger Sheets, if applicable
- Last three months Bowel Tracking Sheets (if medium or high risk for constipation and bowel obstruction requiring a plan of care)
- Last three months Treatment Records, including current month
- Last three months Weight records (including current month), if unplanned weight gain or loss has occurred requiring a plan of care
- Last three months of Seizure Records (including current month) and corresponding documentation in the IPN note, if applicable
- To show implementation of the individual's IHCP, any flow sheets or other associated documentation not already provided in previous requests
- Last six months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last three months of MARs (i.e., including front and back of MARs)
- Last three months Self Administration of Medication (SAMs) Program Data Sheets, as implemented by Nursing
- Adverse Drug Reaction Forms and follow-up documentation
- For individuals that have been restrained (i.e., chemical or physical), the Crisis Intervention Restraint Checklist, Crisis Intervention Face-to-Face Assessment and Debriefing, Administration of Chemical Restraint Consult and Review Form, Physician notification, and order for restraint
- Signature page (including date) of previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one's signature page here)
- Last three quarterly medical reviews
- Preventative care flow sheet
- Annual dental examination and summary, including periodontal chart, and signature (including date) page of previous dental examination
- For last six months, dental progress notes and IPNs related to dental care
- Dental clinic notes for the last two clinic visits
- For individuals who received medical and/or dental pre-treatment sedation, all documentation of monitoring, including vital sign sheets, and nursing assessments, if not included in the IPNs.
- For individuals who received general anesthesia/TIVA, all vital sign flow sheets, monitoring strips, and post-anesthesia assessments

- For individuals who received TIVA or medical and/or dental pre-treatment sedation, copy of informed consent, and documentation of committee or group discussion related to use of medication/anesthesia
- ISPAs, plans, and/or strategies to address individuals with poor oral hygiene and continued need for sedation/TIVA
- For any individual with a dental emergency in the last six months, documentation showing the reason for the emergency visit, and the time and date of the onset of symptoms
- Documentation of the Pharmacy's review of the five most recent new medication the orders for the individual
- WORx Patient Interventions for the last six months, including documentation of communication with providers
- When there is a recommendation in patient intervention or a QDRR requiring a change to an order, the order showing the change was made
- Adverse Drug Reaction Forms and follow-up documentation
- PCP post-hospital IPNs, if any
- Post-hospital ISPAs, if any
- Medication Patient Profile form from Pharmacy
- Current 90/180-day orders, and any subsequent medication orders
- Any additional physician orders for last six months
- Consultation reports for the last six months
- For consultation reports for which PCPs indicate agreement, orders or other documentation to show follow-through
- Any ISPAs related to consultation reports in the last six months
- Lab reports for the last one-year period
- Most recent colonoscopy report, if applicable
- Most recent mammogram report, if applicable
- For eligible women, the Pap smear report
- DEXA scan reports, if applicable
- EGD, GES, and/or pH study reports, if applicable
- Most recent ophthalmology/optometry report
- The most recent EKG
- Most recent audiology report
- Clinical justification for Do Not Resuscitate Order, if applicable
- For individuals requiring suction tooth brushing, last two months of data showing implementation
- PNMT referral form, if applicable
- PNMT minutes related to individual identified for the last 12 months, if applicable
- PNMT Nurse Post-hospitalization assessment, if applicable
- Dysphagia assessment and consults (past 12 months)
- IPNs related to PNMT for the last 12 months
- ISPAs related to PNMT assessment and/or interventions, if applicable
- Communication screening, if applicable
- Most recent Communication assessment, and all updates since that assessment
- Speech consultations, if applicable
- Any other speech/communication assessment if not mentioned above, if any within the last 12 months

- ISPAs related to communication
- Skill Acquisition Programs related to communication, including teaching strategies
- Direct communication therapy plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to communication
- Communication dictionary
- IPNs related to speech therapy/communication goals and objectives
- Discharge documentation for speech/communication therapy, if applicable
- OT/PT Screening
- Most recent OT/PT Assessment, and all updates since that assessment
- OT/PT consults, if any
- Head of Bed Assessment, if any within the last 12 months
- Wheelchair Assessment, if any within the last 12 months
- Any other OT/PT assessment if not mentioned above, if any within the last 12 months
- ISPAs related to OT/PT
- Any PNMPs implemented during the last six months
- Skill Acquisition Programs related to OT/PT, including teaching strategies
- Direct PT/OT Treatment Plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to OT/PT
- IPNs related to OT/PT goals and objectives
- Discharge documentation for OT/PT therapy, if applicable
- REISS screen, if individual is not receiving psychiatric services

The individual-specific documents listed below:

- ISP document
- IRRF, including any revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment
- Active Problem List
- All ISPAs for past six months
- QIDP monthly reviews/reports (and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request)
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- These annual ISP assessments: nursing, habilitation, dental, rights
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment

- Functional Skills Assessment and FSA Summary
- PSI
- QIDP data regarding submission of assessments prior to annual ISP meeting
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted after 1/1/14, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- The individual's daily schedule of activities.
- Documentation for the selected restraints.
- Documentation for the selected DFPS investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation.

- A list of all injuries for the individual in last six months.
- Any trend data regarding incidents and injuries for this individual over the past year.
- If the individual was the subject of an injury audit in the past year, audit documentation.

For specific individuals who have moved to the community:

- ISP document (including ISP action plan pages)
- IRRF
- IHCP
- PSI
- ISPAs
- CLDP
- Discharge assessments
- Day of move checklist
- Post move monitoring reports
- PDCT reports
- Any other documentation about the individual's transition and/or post move incidents.

APPENDIX B - List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
ADL	Adaptive living skills
AED	Antiepileptic Drug
AMA	Annual medical assessment
APC	Admissions and Placement Coordinator
APRN	Advanced Practice Registered Nurse
ASD	Autism Spectrum Disorder
BHS	Behavioral Health Services
CBC	Complete Blood Count
CDC	Centers for Disease Control
CDiff	Clostridium difficile
CLDP	Community Living Discharge Plan
CNE	Chief Nurse Executive
CPE	Comprehensive Psychiatric Evaluation
CPR	Cardiopulmonary Resuscitation
CXR	Chest x-ray
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
DOJ	Department of Justice
DSHS	Department of State Health Services
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
EC	Environmental Control
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
ENT	Ear, Nose, Throat
FSA	Functional Skills Assessment
GERD	Gastroesophageal reflux disease
GI	Gastroenterology
G-tube	Gastrostomy Tube
Hb	Hemoglobin

HCS	Home and Community-based Services
HDL	High-density Lipoprotein
HRC	Human Rights Committee
ICF/IID	Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions
IDT	Interdisciplinary Team
IHCP	Integrated Health Care Plan
IM	Intramuscular
IMC	Incident Management Coordinator
IOA	Inter-observer agreement
IPNs	Integrated Progress Notes
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IV	Intravenous
LVN	Licensed Vocational Nurse
LTBI	Latent tuberculosis infection
MAR	Medication Administration Record
mg	milligrams
ml	milliliters
NMES	Neuromuscular Electrical Stimulation
NOO	Nursing Operations Officer
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PDCT	Potentially Disrupted Community Transition
PEG-tube	Percutaneous endoscopic gastrostomy tube
PEMA	Psychiatric Emergency Medication Administration
PMM	Post Move Monitor
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PRN	pro re nata (as needed)
PT	Physical Therapy
PTP	Psychiatric Treatment Plan
PTS	Pretreatment sedation

QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
RDH	Registered Dental Hygienist
RN	Registered Nurse
SAP	Skill Acquisition Program
SO	Service/Support Objective
SSLC	State Supported Living Center
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
UTI	Urinary Tract Infection
VZV	Varicella-zoster virus